449. MAXIMUM PAYMENT TO HOSPITALS. Pursuant to the provisions of Title XIX of the Social Security Act, in reimbursing hospitals, the Department will pay in behalf of MA recipients the lesser of Customary Charges or the Reasonable Cost of inpatient services in accordance with procedures detailed in Sections 450 through 499. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment which would be determined as a Reasonable Cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

- Indian Health Hospitals. Payment for Indian Health Services (IHS)/tribal 638 inpatient hospital services is made at the most current inpatient hospital per diem rate published by IHS in the Federal Register.

450. EXEMPTION OF NEW HOSPITALS. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of Reasonable Cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs.

451. DEFINITIONS. In determining hospital reimbursement on the basis either of Customary Charges or of the Reasonable Cost of inpatient services under Medicaid guidelines, whichever is less, the following will apply:

- Allowable Costs. The Current Year's Title XIX apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual Parts I and II (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation.

- Apportioned Costs. Apportioned Costs consist of the share of a hospital's total allowable costs attributed to Medicaid program recipients and other patients so that the share borne by the program is based upon actual services received by program recipients, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in Provider Reimbursement Manual, PRM—15, and in compliance with Medicaid reimbursement rules.

- Capital Costs. For the purposes of hospital reimbursement, Capital Costs are those allowable costs considered in the final settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes.

- Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the Current Year will be divided by the index of the Principal Year to assess the percent change between the years.
- Charity Care. Charity Care is care provided to individuals who have no source of payment third-party or personal resources.
- Children's Hospital. A Children's Hospital is a Medicare certified hospital as set forth in 42 CFR Section 412.23 (d)
- Cost Report. A Cost Report is the complete Medicare cost reporting form Centers For Medicare and Medicaid Services (CMS) 2552, or its successor, as completed in full and accepted by the Intermediary for Medicare cost settlement and audit.
- Current Year. Any hospital cost reporting period for which Reasonable Cost is being determined will be termed the Current Year.
- Customary Charges. Customary Charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services and billed to the Title XIX program. No more than ninety-six and one-half percent (96.5%) of covered charges will be reimbursed for the separate Operating Costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 453.
- Disproportionate Share Hospital (DSH) Allotment Amount. The Disproportionate Share Hospital (DSH) Allotment Amount is determined by CMS which is eligible for federal matching funds in the federal fiscal period for disproportionate share payments.
- Disproportionate Share Threshold. The Disproportionate Share Threshold shall be: a. the arithmetic mean plus one (1) standard deviation of the Medicaid Inpatient Utilization Rates of all Idaho hospitals; or, b. a Low Income Utilization Rate exceeding twenty-five percent (25%).

- DSH Survey. The DSH Survey is an annual data request from the Department to the hospitals, to obtain the information necessary to compute DSH pursuant to Subsection 454.02.
- Excluded Units. Excluded Units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29, for exclusion from the Medicare prospective payment system.
- Hospital Inflation Index. The table named Global Insight Hospital Market Basket in the reference manual published by Global Insight titled "Health-Care Cost Review," or its successor, is used to calculate the quarterly moving average inflation rate.
- Medicaid Inpatient Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH Survey. In this paragraph, the term "inpatient days" includes newborn days, days in specialized wards, and days provided to an inappropriate level of care. Days provided at an inappropriate level of care includes Medicaid swing-bed and administratively necessary days, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH Threshold computations.
- Low Income Utilization Rate. The Low Income Utilization Rate is the sum of the following fractions, expressed as a percentage: a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payers, or cash for patient services received directly from state and local governments county assistance programs.
- Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted.
- Obstetricians - For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the Federal Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

- Operating Costs. For the purposes of hospital reimbursement, Operating Costs are the allowable costs included in the cost centers established in the finalized Medicare Cost Report to accumulate costs applicable to providing routine, and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process.
- Other Allowable Costs. Other Allowable Costs are those Reasonable Costs recognized under the Medicaid Reasonable Cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as Operating Costs, but recognized by Medicare principles as Allowable Costs will be included in the total Reasonable Costs. Other Allowable Costs include, but are not necessarily limited to, physician's component which was combined-billed, Capital Costs, ambulance costs, excess costs carry-forwards and medical education costs.
- Principal Year. The Principal Year is the period from which the Title XIX inpatient operating cost limit is derived: a. For services rendered from July 1, 1987 through July 5, 1995, the Principal Year shall be the provider's fiscal year ending in calendar year 1984 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement: b. For inpatient services rendered after July 5, 1995, through June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1992 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement; c. For inpatient services rendered after June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1995 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement.
- Public Hospital. For purposes of Subsection 453, a Public Hospital is a hospital operated by a Federal, State, county, city, or other local government agency or instrumentality.

- Reasonable Costs. Except as otherwise provided in section 453. Reasonable Costs includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service, which do not exceed the Title XIX cost limit.
- Reimbursement Floor Percentage. The percentage of allowable Medicaid costs guaranteed of hospitals with licensed and Medicare certified inpatient bed for State Fiscal year ending June 30, 2002 and thereafter. Eighty-one an one half percent (81.5%).
- Reimbursement Ceiling Percentage. The percentage of allowable Medicaid costs to hospitals with licensed and Medicare certified inpatient beds will not exceed ninety-six an one half percent (96.5%) November 1, 2002 and thereafter.
- TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248.
- Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the State Allotment Amount, only inpatient costs of uninsured patients will be considered. An inpatient with insurance but no benefit covered for the particular medically necessary service, procedure or treatment provided is an uninsured patient.
- Upper Payment Limit. The Upper Payment Limit for hospital services shall be as defined in the Chapter 42 of the Code of Federal Regulations.

452. TITLE XIX INPATIENT OPERATING COST LIMITS: a. Title XIX Cost *Limits for Dates of Service Prior to a Current Year. The reimbursable* Reasonable Costs for services rendered prior to the beginning of the Principal Year, but included as prior period claims in a subsequent period's Cost Report will be subject to the same operating cost limits as the claims under settlement; b. Application of the Title XIX Cost Limit. In the determination of a hospital's Reasonable Costs for inpatient services rendered after the effective date of a Principal Year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the Operating Costs, excluding capital costs and other allowable costs as defined by Subsection 451 for the Principal Year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index: (i) Each inpatient routine service cost center, as reported in the finalized Principal Year end Medicare Cost Report, will be segregated in the Title XIX cost limit calculation and assigned a share of total Title XIX inpatient ancillary costs. The prorated ancillary costs shall be determined by the ratio of each Title XIX routine cost center's reported costs to total Title XIX inpatient routine service costs in the Principal Year; (ii) Each routine cost center's total Title XIX routine service costs plus the assigned share of Title XIX inpatient ancillary costs of the Principal Year will be divided by the related Title XIX patient days to identify the total costs per diem in the Principal Year; The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in 452 to identify each inpatient routine service cost center per diem cost limit in the Principal Year; If a provider did not have any Title XIX inpatient utilization or render any Title XIX inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the Principal Year, the Principal Year for only those routine cost centers without utilization in the provider's Principal Year will be appropriately calculated using the information available in the next subsequent year in which Title XIX utilization occurred; c. Each routine cost center's cost per diem for the Principal Year will be multiplied by the Hospital Inflation Cost Index; d. The sum of the per diem cost limits for the Title XIX inpatient routine service cost centers of a hospital during the Principal Year, as adjusted by the Hospital Inflation Index, will be the Title XIX cost limit for Operating Costs in the Current Year. At the date of final settlement, reimbursement of the Title XIX Current Year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem Operating Costs as adjusted for each subsequent fiscal year after the Principal Year through the Current Year by the Hospital Inflation Cost Index. Providers will be notified of the Hospital inflation index upon written request.

453. ADJUSTMENTS TO THE TITLE XIX COST LIMIT. A hospital's request for review by the Bureau of Medicaid Policy and Reimbursement, or its successor, concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Sections 450 through 499, shall be granted under the following circumstances (see Appendix 1.):

- Adjustments Because of Extraordinary Circumstances. Where a provider's costs exceed the Title XIX limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects.
- Reimbursement to Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to or greater than its costs.
- Adjustment to Cost Limits. A hospital shall be entitled to a reasonable increase in its Title XIX Cost Limits if the hospital shows that its per diem costs of providing services have increased due to increases in case-mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the Principal Year. Any hospital making such showing shall be entitled to an increase in its prevailing Title XIX Cost Limits commensurate with the increase in per diem costs; a. The Title XIX Operating Cost Limit may be adjusted by multiplying the ratio of the Current Year's Case-Mix Index divided by the Principal Year's Case-Mix Index. The contested case procedure set forth in IDAPA 16.05.03.330.02 shall be available to larger hospitals seeking such adjustments to their Title XIX Cost Limits.
- Hospitals will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement, excluding DSH payments; a. With the exception of Subsection b, at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage defined for each state fiscal year end; b. In the event that CMS informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals.

Adjustment to the Proration of Ancillary Costs in the Principal Year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total allowable Title XIX Operating, Capital and medical eduction costs, per diem calculated for the inpatient routine service cost centers in the Principal Year, the provider may submit a detailed analysis of ancillary services provided to each Title XIX recipient (for each type of patient day during each recipient's stay during the Principal Year). The provider will be granted this adjustment only once upon appeal prior to notice of program reimbursement for the provider's fiscal year ending.

454. *Adjustment for Disproportionate* Share Hospitals (DSH). All hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as a Deemed DSH to receive a DSH payment.

01. DSH Survey Requirements. On or before January 31, of each calendar year, the Department will send each hospital a DSH survey. Each hospital shall return the DSH Survey on or before May 31 of the same calendar year. A hospital shall not be entitled to a DSH payment if the hospital fails to return the DSH survey by the May 31 deadline without good cause as determined by the Department. From the DSH Survey and Department data, payments distributing the state's annual DSH allotment amount will be made by September 30 of the same calendar year.

02. Mandatory Eligibility for DSH Status shall be provided for all hospitals which:

a. meet or exceed the Disproportionate Share Threshold as defined in Subsection 451.12.

b. have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services, and has provided such services to individuals entitled to such services under the Idaho Medical Assistance Program for the reporting period.

i. Subsection 454.02.b does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or

ii. Did not offer non-emergency inpatient obstetric services as of December21, 1987.

c. The MUR shall be not less than one percent (1%)

d. If a hospital exceeds both Disproportionate Share thresholds set forth in Subsection 451.12 and the criteria of Subsections 454.02 b and c are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 454.02 f through j.

e. In order to qualify for a DSH payment, a hospital located outside the State of Idaho shall:

i. Qualify under the mandatory DSH requirements set forth in this Section;

ii. Qualify for DSH payments from the state in which the hospital is located; and

iii. Receive $50,000 or more in payments for services provided to Idaho recipients during the year covered by the applicable DSH Survey.

f. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one half (1.5) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to two percent (2%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

g. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one half (1.5) standard deviations and less than two (2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to four percent (4%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

h. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

i. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates exceeding twenty five percent (25%) but less than thirty percent (30%) shall receive a DSH payment equal to four percent (4%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

j. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding thirty percent (30%) shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

03. Out-of-State Hospitals Eligible for Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (of the percentages provided for Idaho hospitals in Subsections 02.d through 02.j). Mandatory qualifications in sections 454.02.a, b, c, and e, must also be met.

04. Deemed Disproportionate Share Hospital (DSH) All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 454.02, will be designated a Deemed Disproportionate Share Hospital. Out of state hospitals will not be as Deemed DSH. The disproportionate share payment to a Deemed DSH hospital shall be the greater of:

a. Five dollars ($5.00) per Medicaid inpatient day included in the hospital's MUR computation; or

b. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the Disproportionate Share Hospital Allotment Amount less the Mandatory DSH payment amount divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals.

c. The Deemed DSH inpatient utilization rate will be each hospital's Idaho Medicaid inpatient days divided by the total number of patient days reported in the annual DSH survey.

d. Deemed DSH eligibility and payments are based on an allocation of the remaining DSH allotment after Mandatory DSH hospital obligations are met. If Mandatory DSH hospitals receive 100 percent of the DSH allotment, deemed DSH hospitals will not be eligible to receive a DSH payment for that allotment period.

05. Insufficient DSH Allotment Amount. When the DSH Allotment Amount is insufficient to make the aggregate amount of DSH payments, DSH payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. On a quarterly basis, the state shall monitor DSH payments against the DSH Allotment Amount.

06. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the uncompensated costs incurred during the year of furnishing services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State plan, plus the costs of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

a. Payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State shall not be considered a source of third party payment.

b. Claims of uncompensated costs that increase the maximum amount which a hospital may receive as a DSH payment must be documented.

455. ORGAN TRANSPLANT AND PROCUREMENT REIMBURSEMENT Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of ninety-six an half (96.5%) of Reasonable Cost under Medicare payment principles or Customary Charges. Follow up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered.

456. OUT-OF-STATE HOSPITALS.

01. Cost Settlements for Certain Out-of- Hospitals. Hospitals not located in the State of Idaho will have a cost settlement computed with the State of Idaho if the following

conditions are met:

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or

b. When less than fifty thousand dollars ($50,000) of the covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department.

02. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges. This rate represents an average inpatient reimbursement rate paid to Idaho hospitals.

03. Payment for Out of State Hospitals that Perform Specialized Services or Procedures Unavailable at Instate Hospitals. In cases where the Department determines that a Medicaid client is having access difficulty because there are no instate hospitals available that can perform the particular service or procedure needed, the Department may negotiate a payment rate with an out of state hospital that can perform the service or procedure needed, rather than cost settling with them. The Department will set a payment rate that will reimburse the hospital on a reasonable cost basis under Medicare cost reimbursement principles. The established payment ceiling will be 100% of costs, and the payment floor will be 30% of inpatient covered charges or 100% of costs, whichever is less. Outpatient covered charges will be reimbursed based on payment for hospitals without cost settlement, as outlined in Attachment 4.19-B.

457. SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT-OWNED HOSPITALS. Subject to the provisions of this section, eligible providers of Medicaid inpatient hospital services shall receive a supplemental payment each state fiscal year. Eligible providers are non-state government-owned hospitals, including critical access hospitals and district hospitals.

The supplemental payments are intended to be used to improve access to health care in rural areas and potentially to fund or offset costs of the uninsured. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles up to 100% allowable Medicare payment level. Supplemental payments made to the non-state governmental-owned hospitals will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid inpatient days to total inpatient days within the group.

The supplemental payments made to non-state government-owned hospitals are subject to prior federal approval, legislative appropriation, and a contractual commitment by the hospitals not to allow expenditures paid for by the supplemental payments to be included in costs used to set Medicaid hospital payment rates.

The supplemental payments shall not be subject to rules governing payments to hospitals found in IDAPA 16.03.10. However, they shall not exceed 100% of federal Medicare upper limit for non-state government-owned hospital payments. The Medicare upper payment limit analysis will be performed prior to making the supplemental payments.

The supplemental payments will be made for Medicaid services provided on or after the period August 1 through September 30, 2001, and then for each federal fiscal year thereafter, authorized by federal law. ~~This change will increase federal Medicaid payments to eligible hospitals.~~

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458. INSTITUTIONS FOR MENTAL DISEASE (IMD). Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care in a freestanding psychiatric hospital will be covered.

459. AUDIT FUNCTION. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Title XIX purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility.

460. ADEQUACY OF COST INFORMATION. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to recipients. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of Reasonable Costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another.

Pen and Ink Change Authorized 6/3/02

461. AVAILABILITY OF RECORDS OF HOSPITAL PROVIDERS. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider.

462. INTERIM COST SETTLEMENTS. The Department will initiate interim cost settlements based on the Medicare cost reports as submitted to the Medicare Intermediary.

01. Interim settlement cost report data will be adjusted to reflect Medicaid payment and statistical summary reports sent to providers before the filing deadline.

02. Hospitals which must undergo cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Bureau of Medicaid Policy and Reimbursement, or its designee, upon filing with the Intermediary.

a. The Department may grant extensions for filing the Medicare cost report for circumstances beyond the provider's control.

b. The Department may limit a recovery or payment of an interim settlement amount up to twenty five percent (25%) of the total settlement amount when the cost report information is in dispute.

463. NOTICE OF PROGRAM REIMBURSEMENT. Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment shall be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Title XIX program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the

settlement amount.

01. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary.

02. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement.

464. INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS TO HOSPITALS. The Title XIX program will charge interest on overpayments, and pay interest on underpayments, to hospitals as follows:

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Section 462., and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense.

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges.

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly.

04. Retroactive Adjustment. The balance and interest shall be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial

appeal process. Interest penalties shall only be applied to unpaid amounts and shall be subordinated to final interest determinations made in the judicial review process.

465. RECOVERY METHODS. Recovery shall be effected by one of the following methods:

- *Lump Sum Voluntary Repayment.* Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department.

- Periodic Voluntary Repayment. The provider may make payments or may have recovery made from interim payments based on a request submitted within thirty (30) days of receipt of the notice or program reimbursement.

- Department Initiated Recovery. The Department shall recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt.

- Recovery from Medicare Payments. The Department may request that Medicare payments be withheld in accordance with 42 CFR Section 405.375.

466. NONAPPEALABLE ITEMS. The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed Cost Reports and audits must not be accepted as appealable items.

467. INTERIM REIMBURSEMENT RATES. The interim reimbursement rates are intended to be reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards.

- Annual Adjustments. Interim rates will be adjusted at least annually based the hospital's most recent final audited Medicare Cost Report. The time period of the annual adjustments vary depending on when we receive the final audited Medicare cost report from the hospital. The interim rate will reflect the Title XIX Inpatient Operating Cost Limits used to set in-patient rates, the reimbursement floor percentage and the reimbursement ceiling percentage.

STATE IDAHO
DATE REC'D 6-25-03
DATE APPV'D 3-2-04
DATE EFF 4-1-03
HCFA 179

A

- Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider.

- Basis for Adjustments. The Department may make an adjustment based on the Medicare Cost Report as submitted and accepted by the Intermediary, after the provider's reporting year, to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than 10% of the payments received or paid and equal to or greater than $100,000, the interim rate will be adjusted to account for half of the difference.

- *Unadjusted Rate.* The Title XIX interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payers.

468. Hospital Swing-Bed Reimbursement. The Department will reimburse hospitals which meet the requirements found in Idaho Department of Health and Welfare Rules, Title 3, Chapter 9, Section 161, Rules Governing Medical Assistance.

469. (RESERVED).

996. ADMINISTRATIVE PROVISIONS. Contested case appeals shall be governed by Idaho Department of Health and Welfare Rules, Title 5, Chapter 3, Sections 000, et seq., Rules Governing Contested Case Proceedings and Declaratory Rulings.

997. CONFIDENTIALITY OF RECORDS. Information received by the Department in connection with Medicaid provider reimbursement is subject to the provisions of Idaho Department of Health and Welfare Rules, Title 5, Chapter 1, Rules Governing Protection and Disclosure for Department Records (See Appendix 1).

998. (RESERVED).

999. ADMINISTRATIVELY NECESSARY DAY (AND). An Administratively Necessary Day is intended to allow a hospital time for an orderly transfer or discharge of recipient inpatients who are no longer in need of a continued acute level of care. AND's may be authorized for

STATE IDAHO
DATE REC'D 6-25-03
DATE APPV'D 3-2-04
DATE EFF 4-1-03
HCFA 179

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inpatients who are awaiting placement for NF level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

01. Documentation Provided. The hospital will provide the Department's designee complete and timely documentation prior to the patient's anticipated discharge date in order to be considered. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing, or by telephone. Hospitals must make the documentation and related information requested by the Department's Medicaid Policy Section designee available within ten (10) working days of the date of the designee-'s request in order for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to:

a. A brief summary of the patient's medical condition; and

b. Statements as to why the patient cannot receive the necessary medical services in a nonhospital setting; and

c. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact.

02. Limitation of Administratively Necessary Days. Each recipient is limited to no more than three (3) ANDs per discharge. In the event that a NF level of care is required, an AND may be authorized provided that the hospital documents that no SNF or ICF bed is available within twenty-five (25) miles of the hospital.

03. Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho skilled nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation.

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year.

b. Hospitals with an attached skilled nursing facility

will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and

c. The Department will pay the lesser of the established AND rate or a facility's customary charge to private pay patients for an AND.

04. Reimbursement for Services. Routine services as addressed in Subsection 161.01.a. include all medical care, supplies, and services which are included in the calculation of nursing home property and nonproperty costs as described in Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 126. (12-31-91)

APPENDIX 1 - HOSPITAL APPEALS UNDER CONTESTED CASE RULES

16.05.500. DISPUTED PAYMENTS TO HOSPITALS. If a hospital has a grievance or complaint or requests an exception to the requirements of Idaho Department of Health and Welfare Rules and Regulations Sections 03.10450 -- 03.10499, the hospital can invoke the following procedures:

01. Filing of Dispute. Within thirty (30) days after a provider receives notification of an action or determination, and it has any grievance, complaint, or exception, the provider must identify in writing to the Bureau of Medical Assistance the specific issues involved and specifically describe the disputed action or inaction regarding such issue(s) and the grounds for its contention that an action or determination was erroneous. Any information and copies of any documentation on which the facility intends to rely to support its position shall be included with the initial filing of the dispute.

02. Initial Response to the Dispute. The Bureau of Medical Assistance will acknowledge the written grievance, complaint, or exception and transmit its response to the hospital within thirty (30) days.

03. Intermediate Resolution of the Dispute. If a hospital disputes the conclusions and reasons found in the Bureau of Medical Assistance's response, the hospital can request that the Bureau conduct an informal conference to resolve the issue(s) in dispute.

a. Request. The request for an informal conference must:

i. Be in writing; and

ii. Be specific as to all issues in question: and

iii. Set forth the specific dollar value in question; and

iv. Be supplemented with any pertinent documentation relevant to the hospital's contention(s), as requested by the Bureau prior to the informal conference within thirty (30) days

b. Findings. The results of the informal conference will be transmitted to the hospital in the form of a written letter of findings.

04. Final Determination. If no request for an informal conference is made pursuant to Idaho Department of Health and Welfare Rules and Regulations Section 03.10500,03., within thirty (30) days of the hospital's receipt of the initial response to the dispute, or if no response containing the supplemental information requested by the Department prior to the scheduling of an informal conference, and no good reason why such information is not available to the Department, the initial action or determination per Idaho Department of Health and Welfare Rules and Regulations Section 03.10500,03. will be final; or

a. Grievance. If a hospital is not satisfied with the decision reached in an information conference conducted under the provisions of Idaho Department of Health and Welfare rules and Regulations Section 03.10500,04., it can refer the grievance, complaint, or exception to the Administrator, Division of Welfare, for an additional review; and

b. Final Determination. After considering all findings and recommendations, the Administrator will make a final determination and so advise the hospital, in writing, by certified mail with a return receipt addressed to the Department's Hearing Coordinator. Copies of the Administrator's final determination are also to be forwarded to the Bureau of Medical Assistance.

05. Formal Hearing. After appealing the disputed action or determination to the Bureau of Medical Assistance and receiving the Administrator's final determination regarding the findings and recommendations, the hospital can make a request to the Department for an administrative hearing on any grievance, complaint, or exception in dispute.

a. Conduct of Hearing. Any such hearing must be conducted in compliance with Idaho Department of Health and Welfare Rules and Regulations, Title 5, Chapter 3, "Rules Governing Contested Case Proceedings." The filing of a request for a formal hearing on a disputed payment under the applicable provisions of the Idaho Administrative Procedures Act, Sections 67-5209 -- 67-5218, Idaho Code, is valid only after the provisions in Idaho Department of Health and Welfare Rules and Regulations Sections 03.10500,01. through 03.10500,04. have been exercised, thus exhausting the informal appeal remedies.

b. Deadline for Request. The request must be filed within thirty (30) days following receipt of the Administrator's final determination.

i. Form of Request. The hearing request must be in writing.

ii. Specifications. The hearing request must specify the items still in dispute addressed but not resolved during the informal appeals process. Failure to so specify remaining disputed items will void the request.

c. Parties to the Hearing. In addition to those parties specified in Idaho Department of Health and Welfare Rules and Regulations Section 05.3020,01. Title 5, Chapter 3, "Rules Governing Contested Case Proceedings." parties to the hearing are to include the following:

i. A representative from the Bureau of Medical Assistance; and

ii. A representative from the hospital; and

iii. If desired, counsel for the Department and the hospital.

d. Hearing Decisions. The Hearing Officer will render a proposed decision pursuant to Idaho Department of Health and Welfare Rules and Regulations Sections 05.3030,02. -- 05,3030,03., Title 5, Chapter 3, "Rules Governing Contested Case Proceedings." Such decision must be rendered in writing within forty-five (45) days of the hearing and will stand pending a rehearing or an appeal pursuant to the provisions contained in Idaho Department of Health and Welfare Rules and Regulations Sections 05.3030,04. and 05.3030,07. -- 05,3030,12., Title 5, Chapter 3.

06. Judicial Review on Appeal. In accordance with Title 67, Chapter 52, Idaho Code, and Idaho Department of Health and Welfare Rules and Regulations, Title 5, Chapter 3, a hospital which has exhausted all administrative remedies available within the Department can seek judicial review. Proceedings for review are to be instituted in accordance with Section 67-5215, Idaho Code.

State: Idaho

ATTACHMENT 4.19-A

APPENDIX 2

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Transmittal Number: 01-005
Supersedes Number: _____

Date Approved: DEC 21 2001
Effective Date: 8-1-01

ATTACHMENT 4.19-B

Page 1.

Minimum payment to noninstitutional providers of services for individuals eligible for Medicare and Medicaid will be as follows: Medicaid will pay the lesser of the Medicaid allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together.

Establishment of payment rates for the following types of care are provided under the program:

1. Inpatient Hospital Services-Refer to Attachment 4.19-A.

2. a. Outpatient Hospital Services. Outpatient hospital services must be provided on-site. Covered outpatient services and items by the Department will be paid in behalf of Medical Assistance clients at the lesser of customary charges or the reasonable cost of inpatient services and in accordance with the upper payment limits specified in Chapter 42 of the Code of Federal Regulations Section 447.321. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

   i. Payment to hospitals for clinical diagnostic laboratory tests rendered to outpatients and nonpatients will be paid at a rate not to exceed Medicare's fee schedule for each of those types of services. Exceptions included in Section 2303 (d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit, or its successor's, fee schedule.

   ii. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of:

a) The hospital's reasonable costs as reduced by federal mandates to certain operating costs, capital costs, customary charges; or

b) The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to freestanding Ambulatory Surgical Centers.

c) The blended rate for dates of service on or after July 1, 1995, is equal to the sum of forty- two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount.

iii. Hospital Outpatient Radiology Services. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services.

a) The aggregate payment for hospital outpatient radiology services furnished on or after July 1, 1995, will be equal to the lesser of:

b) the hospital's reasonable costs; or

c) the hospital's customary charges; or

d) the blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount.

e) The hospital specific amount will have operating costs and capital amounts reduced by any percentages mandated by the federal government for the Medicare program.

iv. Reduction to Outpatient Hospital Costs. With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospitals' outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital component.

v. Payments for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than eighty percent (80%) of outpatient covered charges or the department's established fee schedule for certain outpatient services. This rate represents an average outpatient reimbursement rate paid to Idaho hospitals.

2. a. vi. Patient Education: Outpatient Hospital Diabetic Education and Training Program Limited diabetic education and training services rendered through programs recognized by the American Diabetes Association, or provided by Certified Diabetes Educators are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule.

b. **Rural Health Clinics** – A Rural Health Clinic (RHC) is a facility located in a rural area designated as a shortage area, and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases.

i. Care and Services Provided – RHC services are defined as follows:

a. Physician services; or

b. Services and supplies incidental to physician services including drugs and biologicals which cannot be self administered; or

c. Physician assistant services; or

d. Nurse practitioner or clinical nurse specialist services; or

e. Clinical psychologist services; or

f. Clinical social worker services; or

g. Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered if furnished by or incident to a physician service; or

h. In the case of a RHC that is located in an area that has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual.

ii. Encounter – An encounter is a face-to-face contact for the provision of a medical or mental service, between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse, clinic social worker, clinical psychologist, or other specialized nurse practitioner.

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2. b. ii. a. Contacts with more than one (1) discipline of health professional (medical, or mental,) in the same day and in the same location constitute a separate encounter (limited to two (2) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, and mental conditions.

(1) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

(2) Multiple contacts with clinic staff of the same discipline (as defined in Attachment 4.19-B.c.i.a-h) on the same day related to the same illness or injury are considered a single encounter.

b. Services incidental to a billable encounter include in-house radiology, in-house laboratory services, injectable medications, medical equipment and supplies.

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c. ~~Any other medical service is excluded from the encounter rate calculations.~~

iii. Conditions of Participation - A qualified RHC applicant will be recognized as a Medicaid provider with the following stipulations:

a. The provider is confirmed as eligible by the Public Health Service and CMS on and after April 1, 1990; and

2. b. iii. b. Written agreements between the provider and subcontractors will state that the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify that failure to maintain such records voids the agreement between the subcontractor and the provider.

iv. **REIMBURSEMENT - GENERAL**

Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

a. All Rural Health Clinic services are reimbursed on a prospective payment system for services furnished on or after January 1, 2001 and each succeeding fiscal year.

b. An encounter rate will be established for medical/mental separately. These encounter rates will be set up prospectively using the center's reasonable medical/ mental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the perspective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental rates for the period 1.1.2001 to 9.30.2001.

c. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The RHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the RHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

2. b. iv. d. A change in the scope of services is defined to include such things as ~~significant expansion or remodeling of an existing clinic,~~ addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic that could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

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e. Until the State transitions to the prospective payment system, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

f. For newly qualified RHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

g. In the case of any RHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

h. The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be ~~treated as ambulatory services, and excluded from the encounter rate calculation.~~ included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

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2. c. **Federally Qualified Health Center** (FQHC) - Effective retroactively to April 1, 1990, federally qualified health centers are defined as community health centers, migrant health centers, providers of care for the homeless, outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act, as well as clinics that qualify but are not actually receiving grant funds under section 329, 330, or 340 of the Public Health Service Act may provide ambulatory services to Medical Assistance recipients.

i. Care and Services Provided - FQHC services are defined as follows:

a. Physician services; or

b. Services and supplies incidental to physician services including drugs and biologicals which cannot be self administered; or

c. Physician assistant services; or

d. Nurse practitioner or clinical nurse specialist services; or

e. Clinical psychologist services; or

f. Clinical social worker services; or

g. Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, dentist, or dental hygienist services as would otherwise be covered if furnished by or incident to a physician service; or

h. Dental services including both the licensed dentist and dental hygienist; or

i. In the case of an FQHC that is located in an area that has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual; and

2. c. i. j. Other Title XIX payable ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide; including pneumocccal or immunization vaccine and its administration.

ii. Encounter - An encounter is a face-to-face contact for the provision of medical, mental, or dental service between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse, clinic social worker, clinical psychologist, other specialized nurse practitioner, dentist or dental hygienist.

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a. Contacts with more than one (1) discipline of health professional (medical, mental, or dental) in the same day and in the same location constitute a separate encounter (limited to three (3) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, mental, and dental health issues.

(1) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

(2) Multiple contacts with clinic staff of the same discipline (as defined in Attachment 4.19-B.c.i.a-j) on the same day related to the same illness or injury are considered a single encounter.

2. c. ii. b. Services incidental to a billable encounter include in-house radiology, physical therapy, occupational therapy, speech therapy, audiology services, in-house laboratory services, in-house nutritional education or dietary counseling and monitoring by a registered dietician, injectable medications, medical equipment and supplies.

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~~c. Any other medical service is excluded from the encounter rate calculations.~~

iii. Conditions of Participation - A qualified FQHC applicant will be recognized as a Medicaid provider with the following stipulations:

a. The provider is confirmed as eligible by the Public Health Service and CMS on and after April 1, 1990; and

b. The FQHC applicant will simultaneously terminate its Medicaid Rural Health Clinic and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement.

c. Written agreements between the provider and subcontractors will state that the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify that failure to maintain such records voids the agreement between the subcontractor and the provider.

iv. **REIMBURSEMENT - GENERAL**

Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

a. All Federally Qualified Health Center services are reimbursed on a prospective payment system for services furnished on or after January 1, 2001 and each succeeding fiscal year.

2. c. iv. b. An encounter rate will be established for medical/mental and dental encounters separately. These encounter rates will be set up prospectively using the center's reasonable medical/mental and dental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the ~~perspective~~ prospective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental and dental rates for the period 1.1.2001 to 9.30.2001.

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c. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental and dental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The FQHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the FQHC's scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

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d. A change in the scope of services is defined to include such things as ~~significant expansion or remodeling of an existing clinic,~~ addition of new services, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic that could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

e. Until the State transitions to the prospective payment system, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

2. c. iv. f. For newly qualified FQHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

g. In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

h. The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be ~~treated as ambulatory services, and excluded from the encounter rate calculation.~~ included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

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3. Other Laboratory and Radiology Services - The maximum allowable fees for such services do not exceed reasonable charges established by Medicare (Part B). Payment for clinical diagnostic laboratory tests rendered by independent laboratories will not exceed Medicare's fee schedule for non patients. Exceptions included in Section 2303(d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit fee schedule.

4. a. Nursing Facility Services for Individuals Over 21 Years of Age - Refer to Attachment 4.19-D.

b. Special Services Under EPSDT - The State will use the reimbursement methods discussed in this attachment for services in excess of program limitations. These are as follows:

i. Ambulatory Services	Section of Attachment 4.19-B
a. Emergency Room Visits over 6/yr	Section 2a
b. Physician Psychiatrist Evaluation and Psychotherapy	Section 5a
c. Home Health Visits	Section 7
d. Physical Therapy	Section 11a
e. Rehabilitation Services - Developmental Disability Centers	Section 13d
f. Clinic Services	Section 9
g. Case management - (Same method as currently used for PCS Case Management)	Section 19
h. Nutritional Services	Section 20
i. Drugs	Section 12
j. Oxygen and Related Equipment	Section 7c
k. Personal Care Services	Section 24f
l. Eyeglasses	Section 12d
m. Dental	Section 10
n. Hearing Aids	Section 12c
o. Substance Abuse	Section 1,2 and 9

92-3

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ii.	Inpatient Services	Attachment 4.19-A
	a. Substance Abuse	Attachment 4.19-A
	b. Organ Transplants	Attachment 4.19-A

iii. EPSDT Private Duty Nursing Services - are reimbursed by way of the lowest of the provider's actual charge for the services; or the maximum allowable charge for that service as established by the Department's Medical Assistance Unit pricing file.

iv. EPSDT Respiratory Care Services - are reimbursed on a fee schedule established by the Department's Medical Assistance Unit, or the provider's usual and customary charges, whichever is less.

c. Family Planning Services - The Department's Medical Assistance Unit upper limit for reimbursement is the lower of:

i. The family planning providers' actual charge; or

ii. The allowable charge as established by the Department's Medical Assistance Unit fee schedule.

iii. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. Contraceptives requiring a prescription are payable subject to attachment 4.19-B section 12.A prescription drugs. Payment for oral contraceptives is limited to purchase of a three (3) month supply. Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost.

92-3

4/28/92
3/1/92

5. a. Physicians – The Department's Medical Assistance Unit upper limit for reimbursement is the lower of: The physician's actual charge for a service; or

   i. The maximum allowable charge as established by the Department's Medical Assistance Unit fee schedule; if the service or item does not have a specific price on file the provider must submit documentation to the Department and reimbursement will be based on the documentation; or
   ii. The Medicare fee schedule for non patients for clinical diagnostic laboratory tests; or
   iii. For the exceptions in Section 2303 (d) of the Deficit Reduction Act – the Department's Medical Assistance Unit fee schedule.

Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT
59000	$52.71	59852	$729.50	99401	$10.19
59012	$140.64	59855	$351.58	99402	$20.38
59015	$74.72	59856	$527.38	99403	$30.57
59020	$51.84	59857	$641.65	99404	$40.76
59025	$37.23	59870	$290.07	99411	NA
59030	$47.19	59899	BY REPORT	99412	NA
59050	$70.08	99201	$27.63	99420	NA
59051	$61.53	99202	$38.19	99429	BY REPORT
59100	$729.07	99203	$49.42	99432	$75.43
59120	$729.07	99204	$66.52	90700	$23.00
59121	BY REPORT	99205	$77.62	90701	$17.23
59130	$541.41	99211	$22.17	90702	$6.33
59135	$878.41	99212	$28.47	90703	$4.00
59136	$860.44	99213	$33.26	90704	$18.25
59140	BY REPORT	99214	$44.36	90705	$17.55
59150	$527.38	99215	$66.52	90706	$17.55
59151	$729.07	99241	$39.10	90707	$35.00
59160	$219.60	99242	$51.37	90708	$22.30
59200	$57.13	99243	$61.24	90709	$23.32
59300	$133.79	99244	$86.91	90710	NA
59320	$123.06	99245	$114.57	90711	$33.00
59325	$193.37	99271	$37.93	90712	$16.22
59350	$729.07	99272	$47.40	90713	$18.00
59400	$1,191.12	99273	$61.63	90714	$3.00
5940P	$1,103.89	99274	$85.34	90716	$46.00
59409	$667.19	99275	$112.46	90717	$38.00
59410	$776.14	99341	$38.86	90719	$5.00
59412	$196.32	99342	$47.40	90720	$38.00
59414	$175.79	99343	$61.63	90721	$45.00
59425	$230.90	99351	$26.60	90724	$8.00
59426	$318.13	99352	$39.11	90725	$5.00
59430	$112.52	99353	$52.15	90726	$185.00
59510	$1,441.40	99354	$63.22	90727	$4.00
5951P	$1,354.18	99355	$31.61	90728	$5.00
59514	$1,072.34	99358	NA	90730	$63.00
59515	$1,164.22	99359	NA	90732	$15.00
59525	$393.37	99381	$54.05	90733	$11.00
59812	$206.23	99382	$54.05	90737	$18.68
59820	$353.90	99383	$54.05	90741	BY REPORT
59821	$346.56	99384	$66.59	90742	BY REPORT
59830	$219.69	99391	$37.39	90744	$26.00
59840	$325.22	99392	$37.39	90745	$42.00
59841	$448.28	99393	$40.81	90749	BY REPORT
59850	$404.31	99394	$54.53	Q0158	$35.85
59851	$404.31				

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5. a. v. Adequacy of Access. Data obtained from a survey of physician and nurse practitioner charges billed to Medicaid was compiled and analyzed by a Medical Assistance departmental work group. Provider participation (as defined below) has not less than 90% in any of the specialties measured. MMIS output reports are included herewith as documentation.

The attached MMIS outputs document minimum participation rates in any of the reporting quarters included as shown below:

For:	Obstetricians:	100%
	Pediatricians:	90%
	Family and General Practitioners:	100%

Participation for the purpose of this analysis is defined as having treated a minimum of five different recipients, and provided a minimum of ten services and billed charges of at least $200.00, and provided a minimum of fifteen units of service in any quarter reported as "participating."

To comply with the data requirements addressed in the Federal Register of October 3, 1994, page 50237 and 50238, HCFA can be assured that the minimum of $14.34 is allowed for any vaccine administered, because a brief office visit (99211), which allows $22.24, is the least service compensated.

ID-9-HUGR325S-4 MEDICAL SERVICES ANALYSIS FOR IDAHO MEDICAID PAGE NO. 1
RUN DATE - 01/08/97 PROVIDER PEER GROUP SUMMARY PROFILE REPORT PERIOD - OCT 95 DEC 96
CATEGORY OF SERVICE - 4 - PHYSICIAN
REPORT--LOCALITY - IDA - IN STATE TYPE - X20 - PHYSICIAN SPECIALTY - X01 - GP[redacted]
REFERENCE PERIOD - JUL 96-SEP 96 FYID PERIOD - JUL 96-DEC 96 REFERENCE PERIOD PEER GROUP COUNT - 478

----------ACTIVITY SUMMARY----------		TREND	OCT 96 DEC 96	JUL 96 SEP 96	APR 96 JUN 96	JAN 96 MAR 96	OCT 95 DEC 95
NUMBER OF PROVIDERS REPORTING			452	470	487	486	500
NUMBER OF DIFFERENT PATIENTS			11,625	15,428	17,784	18,581	19,445
01-VOLUME SUMMARY SECTION							
02-AMOUNT BILLED - MEDICAID		- 16.58	1,449,404.51	1,653,576.60	3,256,878.72	3,368,945.50	3,441,430.94
03-AMOUNT PAID - MEDICAID	↓50%	- 15.50	825,216.02	1,403,270.72	1,640,715.52	1,746,257.84	1,804,252.96
04-AMOUNT PAID - MEDICARE		- 13.26	40,291.34	70,150.61	84,332.59	143,583.03	85,117.13
05-AMOUNT PAID - TOTAL		- 15.70	865,507.36	1,473,421.53	1,729,048.91	1,890,340.87	1,889,370.09
06-PAID AS PCT OF BILLED		↑ 1.90	56.93	52.88	50.49	51.85	52.42
07-RECIPIENTS SERVED - XIX	↑SD1	- 12.96	11,913.00	16,665.00	19,569.00	20,371.00	21,760.00
08-RECIPIENTS SERVED - XVIII	↑SD1	- 9.60	1,729.00	2,369.00	2,519.00	2,657.00	2,739.00
09-RECIPIENTS SERVED - TOTAL		- 12.59	13,552.00	18,932.00	22,002.00	22,921.00	24,377.00
10-AVG. PAYMENT/RECIPIENT	↑SD1	- 5.55	69.27	84.20	83.96	85.74	82.91
11-AVG. CHARGE/RECIPIENT	↑SD1	- 5.13	121.66	159.23	166.26	165.35	158.15
12-RELATIONAL SUMMARY SECTION							
13-NUMBER OF MEDICAL VISITS		- 16.62	11,673.00	10,152.00	22,227.00	23,003.00	25,737.00
14-PERCENT INITIAL VISITS	↑SD1	- 2.27	27.53	36.76	34.02	31.67	33.77
15-PERCENT EXTENDED VISITS	↑SD1	- 1.50	14.31	19.35	19.93	19.06	15.16
16-AVG. NO. VISITS/RECIPIENT	↑SD1	- 4.53	0.97	1.08	1.13	1.16	1.10
17-AVG. CHG. OFFICE VS/RECIP	↑SD1	- 1.51	30.44	27.66	29.89	32.20	30.44
18-NUMBER OF INJECTIONS		- 21.26	205.00	331.00	456.00	554.00	660.00
19-PAYMENTS FOR INJECTIONS		- 18.46	822.46	987.74	1,736.59	1,394.69	1,078.15
20-AVG. PAYMENT/INJECTION	↑SD1	↑ 1.03	2.00	2.98	3.79	2.51	2.84
21-RATIO INJECTIONS/VISITS	↑SD1	- 5.56	0.02	0.01	0.02	0.02	0.02
22-NO. OF SURGICAL PROCEDURES		- 15.96	979.00	2,179.00	2,479.00	2,615.00	2,473.00
23-PAYMENTS FOR SURGERY		- 15.59	210,451.95	457,749.79	507,617.07	520,344.72	525,449.86
24-RATIO SURGERIES/RECIPIENT	↑SD1	- 1.46	0.08	0.13	0.12	0.12	0.11
25-NO. DIAGNOSTIC X-RAYS		- 13.99	1,110.00	1,820.00	2,225.00	2,275.00	2,205.00
26-PMTS FOR DIAG. X-RAYS		- 10.69	35,326.72	59,634.89	65,891.20	64,012.75	63,849.65
27-RATIO DIAG. X-RAYS/VISIT	↑SD1	↑ 3.26	0.09	0.10	0.10	0.09	0.08
28-NO. LAB PROCEDURES		- 15.78	2,053.00	3,042.00	3,740.00	4,163.00	4,127.00
29-PMTS FOR LAB PROCEDURES		- 15.00	17,580.29	23,991.59	29,628.94	35,100.70	32,070.97
30-RATIO LAB PROCS/VISITS	↑SD1	↑ 0.00	0.17	0.16	0.16	0.18	0.16
31-OTHER DIAG. PROCEDURES		- 11.82	578.00	917.00	1,219.00	1,250.00	1,012.00
32-PMTS FOR OTHER DIAG. PROCS		- 12.78	17,244.08	29,112.08	38,444.51	39,972.03	31,826.37
33-RATIO OTHER DIAG. PROCS/VSITS	↑SD1	↑ 4.55	0.04	0.05	0.05	0.05	0.03
34-PCT INCOME - DIAG SVCS	↑SD1	↑ 5.56	8.50	8.03	8.14	7.96	7.12
35-NUMBER OF CONSULTATIONS	↑5	- 10.69	240.00	387.00	446.00	449.00	415.00
36-PAYMENTS FOR CONSULTATIONS		- 10.41	15,511.65	23,715.90	26,791.88	27,328.89	26,140.32
37-AVG PAYMENT/CONSULTATION	↑SD1	↑ 0.60	64.63	61.27	60.07	60.86	62.98
38-NO. PSYCH VISITS/PSYCH RECIP	↑SD1	↑ 3.37	7.17	9.15	10.33	8.16	6.28
39-NO. ALL OTHER SERVICES		- 9.59	7,877.00	9,487.00	10,471.00	11,431.00	11,831.00
40-PAYMENTS FOR ALL OTHER SERVICES		- 17.98	84,384.35	130,176.51	166,209.62	192,831.82	190,944.20

FYID TOTALS TITLE XIX SVCS 64225 BILLED 4,102,981.11 ALLOWED 2,260,604.19 PAID 2,228,486.94 PCT/PAID/BILLED 54.31
TITLE XVIII 11211 648,011.12 110,737.94 110,441.95 17.04

TN # 97-005 Approval Date: 6-4-97
Supersedes
TN # 96-003 Effective Date: 7-1-97

ID-9-HUGR3253-4 MEDICAL SERVICES ANALYSIS FOR IDAHO MEDICAID PAGE NO. 7
RUN DATE - 01/08/97 PROVIDER PEER GROUP SUMMARY PROFILE REPORT PERIOD - OCT 95 DEC 96
CATEGORY OF SERVICE - 4 - PHYSICIAN
REPORT--LOCALITY - IDA - ID STATE TYPE - X20 - PHYSICIAN SPECIALTY - X08 - FAMILY PRACTICE
REFERENCE PERIOD - JUL 96-SEP 96 FYTD PERIOD - JUL 96-DEC 96 REFERENCE PERIOD PEER GROUP COUNT - 215

----------ACTIVITY SUMMARY----------		TREND	OCT 96 DEC 96	JUL 96 SEP 96	APR 96 JUN 96	JAN 96 MAR 96	OCT 95 DEC 95
NUMBER OF PROVIDERS REPORTING			201	215	205	195	188
NUMBER OF DIFFERENT PATIENTS			7,273	9,185	9,568	9,764	10,001
01-VOLUME SUMMARY SECTION							
02-AMOUNT BILLED - MEDICAID		- 8.36	851,476.19	1,402,870.15	1,509,079.75	1,412,765.56	1,395,306.00
03-AMOUNT PAID - MEDICAID	!50%	- 6.08	529,249.65	814,406.60	832,792.92	796,498.36	790,253.02
04-AMOUNT PAID - MEDICARE		- 15.62	17,244.58	25,994.75	33,777.50	58,375.30	26,277.62
05-AMOUNT PAID - TOTAL		- 7.24	540,194.23	840,351.35	866,570.42	854,823.66	816,530.64
06-PAID AS PCT OF BILLED		+ 1.95	61.41	58.05	55.36	56.37	56.63
07-RECIPIENTS SERVED - XIX	!SD1	- 6.55	7,124.00	9,393.00	9,608.00	9,705.00	9,966.00
08-RECIPIENTS SERVED - XVIII	!SD1	- 6.98	948.00	1,081.00	1,170.00	1,213.00	1,279.00
09-RECIPIENTS SERVED - TOTAL		- 6.72	7,911.00	10,318.00	10,597.00	10,742.00	11,102.00
10-AVG. PAYMENT/RECIPIENT	!SD1	- 0.87	73.40	86.70	86.67	82.06	79.29
11-AVG. CHARGE/RECIPIENT	!SD1	- 2.61	119.52	149.55	156.54	145.57	140.00
12-RELATIONAL SUMMARY SECTION							
13-NUMBER OF MEDICAL VISITS		- 11.53	7,663.00	10,882.00	12,114.00	12,990.00	13,157.00
14-PERCENT INITIAL VISITS	!SD1	- 2.80	15.29	16.50	17.31	16.98	18.72
15-PERCENT EXTENDED VISITS	!SD1	- 2.05	12.16	14.23	12.72	15.37	13.99
16-AVG. NO. VISITS/RECIPIENT	!SD1	- 5.55	1.07	1.15	1.26	1.33	1.32
17-AVG. CHG. OFFICE VST/RECIP	!SD1	- 1.40	38.44	38.63	39.97	41.51	39.77
18-NUMBER OF INJECTIONS		- 2.16	297.00	257.00	326.00	291.00	312.00
19-PAYMENTS FOR INJECTIONS		+ 5.52	596.25	734.29	491.97	594.12	505.00
20-AVG. PAYMENT/INJECTION	!SD1	+ 7.95	2.00	2.85	1.50	2.04	1.61
21-RATIO INJECTIONS/VISITS	!SD1	+ 9.09	0.03	0.02	0.02	0.02	0.02
22-NO. OF SURGICAL PROCEDURES		- 7.16	590.00	1,130.00	1,183.00	1,077.00	972.00
23-PAYMENTS FOR SURGERY		- 3.46	189,930.62	338,295.62	329,550.81	275,611.22	269,808.65
24-RATIO SURGERIES/RECIPIENT	!SD1	- 0.96	0.08	0.12	0.12	0.11	0.09
25-NO. DIAGNOSTIC X-RAYS		- 10.26	179.00	301.00	317.00	306.00	305.00
26-PMTS FOR DIAG. X-RAYS		- 10.12	5,454.75	8,714.39	8,752.52	10,135.37	8,973.06
27-RATIO DIAG. X-RAYS/VISIT	!SD1	+ 0.00	0.02	0.02	0.02	0.02	0.02
28-NO. LAB PROCEDURES		- 9.69	1,414.00	2,139.00	2,403.00	2,444.00	2,301.00
29-PMTS FOR LAB PROCEDURES		- 8.15	11,936.24	16,254.10	18,813.13	18,661.00	17,508.97
30-RATIO LAB PROCS/VISITS	!SD1	+ 1.63	0.18	0.19	0.20	0.18	0.17
31-OTHER DIAG. PROCEDURES		- 14.71	98.00	197.00	175.00	189.00	197.00
32-PMTS FOR OTHER DIAG. PROCS		- 6.25	2,177.52	3,052.80	3,683.41	3,623.26	2,854.40
33-RATIO OTHER DIAG. PROCS/VSITS	!SD1	+ 0.00	0.01	0.01	0.01	0.01	0.01
34-PCT INCOME - DIAG SVCS	!SD1	- 1.58	3.73	3.94	3.74	4.07	3.71
35-NUMBER OF CONSULTATIONS	!S	+ 32.08	14.00	19.00	11.00	5.00	4.00
36-PAYMENTS FOR CONSULTATIONS		+ 34.13	757.12	735.20	494.00	191.23	213.15
37-AVG PAYMENT/CONSULTATION	!SD1	+ 0.45	54.00	38.69	44.90	38.24	53.28
38-NO. PSYCH VISITS/PSYCH RECIP	!SD1	+ 5.93	3.60	7.66	9.47	6.41	2.61
39-NO. ALL OTHER SERVICES		- 2.85	7,507.00	8,524.00	8,887.00	8,697.00	8,623.00
40-PAYMENTS FOR ALL OTHER SERVICES		- 6.17	52,049.57	80,832.55	79,375.51	78,772.15	76,607.90

FYTD TOTALS TITLE XIX	SVCS	41266	BILLED	2,254,366.34	ALLOWED	1,352,866.32	PAID	1,337,356.25	PCT/PAID/BILLED 59.32
TITLE XVIII		6526		220,299.90		43,309.98		43,189.33	19.60

TN # 97-005 Approval Date: 6-4-97
Supersedes
TN # 96-003 Effective Date: 7-1-97

Attachment 4.19-B
5.a.v. (page 4)

ID-9-HUGH325S-9 — MEDICAL SERVICES ANALYSIS FOR IDAHO MEDICAID — PAGE NO. 9

RUN DATE - 01/08/97 — PROVIDER PEER GROUP SUMMARY PROFILE REPORT — PERIOD - OCT 95 DEC 96

CATEGORY OF SERVICE - 4 - PHYSICIAN

REPORT--LOCALITY - IDA - ID STATE — TYPE - X20 - PHYSICIAN — SPECIALTY - X16 - OB-GYN

REFERENCE PERIOD - JUL 96-SEP 96 — FYTD PERIOD - JUL 96-DEC 96 — REFERENCE PERIOD PEER GROUP COUNT - 89

----------ACTIVITY SUMMARY----------		TREND	OCT 96 DEC 96	JUL 96 SEP 96	APR 96 JUN 96	JAN 96 MAR 96	OCT 95 DEC 95
NUMBER OF PROVIDERS REPORTING			90	89	92	93	90
NUMBER OF DIFFERENT PATIENTS			2,479	3,614	4,043	4,264	4,080
01-VOLUME SUMMARY SECTION							
02-AMOUNT BILLED - MEDICAID		- 15.02	1,096,772.22	2,077,737.61	2,367,136.32	2,559,470.08	2,458,341.55
03-AMOUNT PAID - MEDICAID	*50%	- 12.66	619,912.06	1,152,298.11	1,215,616.94	1,306,407.36	1,249,223.49
04-AMOUNT PAID - MEDICARE		- 21.11	1,882.09	3,576.15	6,007.89	6,329.86	5,385.22
05-AMOUNT PAID - TOTAL		- 12.70	621,794.15	1,155,874.26	1,221,624.83	1,312,737.22	1,249,608.71
06-PAID AS PCT OF BILLED	*	- 2.94	56.52	54.87	51.35	51.19	50.61
07-RECIPIENTS SERVED - XIX	*SD1	- 10.29	2,601.00	3,873.00	4,335.00	4,561.00	4,279.00
08-RECIPIENTS SERVED - XVIII	*SD1	- 8.88	103.00	126.00	159.00	134.00	155.00
09-RECIPIENTS SERVED - TOTAL		- 10.19	2,700.00	3,996.00	4,486.00	4,695.00	4,419.00
10-AVG. PAYMENT/RECIPIENT	*SD1	- 5.37	238.33	297.52	280.41	286.43	290.77
11-AVG. CHARGE/RECIPIENT	*SD1	- 6.12	421.67	542.14	546.05	560.06	574.51
12-RELATIONAL SUMMARY SECTION							
13-NUMBER OF MEDICAL VISITS		- 12.52	1,376.00	2,300.00	2,505.00	2,779.00	2,502.00
14-PERCENT INITIAL VISITS	*SD1	- 10.87	14.24	16.30	18.52	20.90	22.15
15-PERCENT EXTENDED VISITS	*SD1	- 5.64	17.75	19.52	19.00	23.78	21.61
16-AVG. NO. VISITS/RECIPIENT	*SD1	- 2.95	0.52	0.59	0.57	0.60	0.60
17-AVG. CHG. OFFICE VST/RECIP	*SD1	- 2.77	22.00	22.89	23.29	24.93	24.23
18-NUMBER OF INJECTIONS		- 14.56	80.00	207.00	211.00	298.00	176.00
19-PAYMENTS FOR INJECTIONS		- 5.46	149.60	2,251.50	2,557.17	1,668.70	844.00
20-AVG. PAYMENT/INJECTION	*SD1	- 1.00	1.80	10.87	12.11	5.59	4.79
21-RATIO INJECTIONS/VISITS	*SD1	- 3.95	0.05	0.09	0.08	0.10	0.06
22-NO. OF SURGICAL PROCEDURES		- 15.07	1,087.00	1,919.00	2,239.00	2,439.00	2,337.00
23-PAYMENTS FOR SURGERY		- 12.61	515,275.19	982,026.73	1,022,606.39	1,088,012.28	1,049,401.18
24-RATIO SURGERIES/RECIPIENT	*SD1	- 6.05	0.41	0.49	0.51	0.53	0.54
25-NO. DIAGNOSTIC X-RAYS		- 19.32	437.00	708.00	852.00	951.00	861.00
26-PMTS FOR DIAG. X-RAYS		- 14.19	30,514.12	50,731.03	58,492.87	68,161.90	59,787.57
27-RATIO DIAG. X-RAYS/VISIT	*SD1	- 2.47	0.31	0.30	0.34	0.34	0.33
28-NO. LAB PROCEDURES		- 15.99	1,231.00	1,922.00	2,409.00	2,692.00	2,330.00
29-PMTS FOR LAB PROCEDURES		- 14.25	9,036.07	14,036.61	19,713.15	22,420.45	18,147.25
30-RATIO LAB PROCS/VISITS	*SD1	- 1.64	0.09	0.03	0.99	0.96	0.90
31-OTHER DIAG. PROCEDURES		- 32.29	10.00	4.00	3.00	7.00	29.00
32-PMTS FOR OTHER DIAG. PROCS		- 16.12	157.71	114.58	77.38	147.99	263.78
33-RATIO OTHER DIAG. PROCS/VSTS	*SD1	* 0.00	0.00	0.00	0.00	0.00	0.00
34-PCT INCOME - DIAG SVCS	*SD1	- 1.16	6.53	5.70	6.43	6.94	6.28
35-NUMBER OF CONSULTATIONS	15	- 10.98	38.00	83.00	94.00	84.00	79.00
36-PAYMENTS FOR CONSULTATIONS		- 13.22	1,763.80	3,505.80	4,215.01	3,814.51	3,801.53
37-AVG PAYMENT/CONSULTATION	*SD1	- 1.89	46.41	42.23	44.84	45.41	49.13
38-NO. PSYCH VISITS/PSYCH RECIP	*SD1	- 35.62	0.00	1.00	0.00	0.00	1.33
39-NO. ALL OTHER SERVICES		- 12.65	1,835.00	2,502.00	2,943.00	3,351.00	3,151.00
40-PAYMENTS FOR ALL OTHER SERVICES		- 10.03	21,031.71	30,636.07	34,986.61	38,802.04	32,032.95

FYTD TOTALS TITLE XIX	SVCS	15740	BILLED	3,196,509.83	ALLOWED	1,798,781.55	PAID	1,772,210.17	PCT/PAID/BILLED	55.44
TITLE XVIII		495		37,001.85		5,458.24		5,458.24		14.75

TN # 97-005 Approval Date: 6-4-97

Supersedes

TN # 96-003 Effective Date: 7-1-97

Attachment 4.19-B
5.a.v. (page 5)

10-9-HUGR325S-4 MEDICAL SERVICES ANALYSIS FOR IDAHO MEDICAID PAGE NO. 19
RUN DATE - 01/08/97 PROVIDER PEER GROUP SUMMARY PROFILE REPORT PERIOD - OCT 95 DEC 96
CATEGORY OF SERVICE - 4 - PHYSICIAN
REPORT--LOCALITY - IOA - IN STATE TYPE - X20 - PHYSICIAN SPECIALTY - X40 - PEDIATRICS
REFERENCE PERIOD - JUL 96-SEP 96 FYTD PERIOD - JUL 96-DEC 96 REFERENCE PERIOD PEER GROUP COUNT - 69

----------ACTIVITY SUMMARY----------		TREND	OCT 96 DEC 96	JUL 96 SEP 96	APR 96 JUN 96	JAN 96 MAR 96	OCT 95 DEC 95
NUMBER OF PROVIDERS REPORTING			64	67	65	60	66
NUMBER OF DIFFERENT PATIENTS			7,050	8,581	9,425	10,307	10,450
01-VOLUME SUMMARY SECTION							
02-AMOUNT BILLED - MEDICAID		- 14.29	797,870.38	1,162,372.40	1,372,106.98	1,536,661.57	1,529,451.01
03-AMOUNT PAID - MEDICAID	†50%	- 12.85	499,093.69	681,799.37	778,905.25	892,393.98	872,360.52
04-AMOUNT PAID - MEDICARE		- 25.72	311.32	420.91	466.51	1,368.63	585.09
05-AMOUNT PAID - TOTAL		- 12.86	499,405.01	682,215.28	779,369.76	893,762.61	872,945.61
06-PAID AS PCT OF BILLED		+ 1.92	62.55	58.65	56.76	58.07	57.22
07-RECIPIENTS SERVED - XIX	†SD1	- 11.09	8,175.00	10,231.00	11,434.00	12,638.00	13,141.00
08-RECIPIENTS SERVED - XVIII	†SD1	- 7.81	57.00	35.00	30.00	41.00	42.00
09-RECIPIENTS SERVED - TOTAL		- 11.08	8,211.00	10,264.00	11,463.00	12,670.00	13,165.00
10-AVG. PAYMENT/RECIPIENT	†SD1	- 2.20	61.05	66.64	68.12	70.61	66.38
11-AVG. CHARGE/RECIPIENT	†SD1	- 3.94	97.59	113.61	120.00	121.59	116.00
12-RELATIONAL SUMMARY SECTION							
13-NUMBER OF MEDICAL VISITS		- 14.79	10,674.00	14,011.00	16,127.00	19,535.00	19,750.00
14-PERCENT INITIAL VISITS	†SD1	- 5.93	5.04	7.22	6.26	6.72	7.12
15-PERCENT EXTENDED VISITS	†SD1	- 2.83	12.63	13.90	13.51	15.60	13.79
16-AVG. NO. VISITS/RECIPIENT	†SD1	- 4.08	1.30	1.36	1.41	1.54	1.50
17-AVG. CHG. OFFICE VST/RECIP	†SD1	- 3.93	93.51	98.17	99.73	98.82	96.88
18-NUMBER OF INJECTIONS		- 29.98	106.00	135.00	86.00	160.00	342.00
19-PAYMENTS FOR INJECTIONS		- 29.89	237.22	1,103.79	1,370.50	2,322.25	1,175.44
20-AVG. PAYMENT/INJECTION	†SD1	- 9.82	2.25	8.17	15.93	14.51	3.43
21-RATIO INJECTIONS/VISITS	†SD1	-100.00	0.00	0.00	0.00	0100	0.01
22-NO. OF SURGICAL PROCEDURES		- 15.71	197.00	409.00	428.00	473.00	504.00
23-PAYMENTS FOR SURGERY		- 15.53	5,970.78	16,161.50	15,092.15	17,480.09	16,341.78
24-RATIO SURGERIES/RECIPIENT	†SD1	- 3.33	0.02	0.04	0.03	0.03	0.03
25-NO. DIAGNOSTIC X-RAYS		- 15.16	176.00	249.00	300.00	321.00	352.00
26-PMTS FOR DIAG. X-RAYS		- 14.32	5,261.21	7,299.63	8,575.35	9,279.19	10,071.03
27-RATIO DIAG. X-RAYS/VISIT	†SD1	+ 0.00	0.01	0.01	0.01	0.01	0.01
28-NO. LAB PROCEDURES		- 8.80	1,811.00	2,259.00	2,262.00	2,684.00	2,620.00
29-PMTS FOR LAB PROCEDURES		- 9.97	14,087.81	16,011.55	16,898.61	20,623.98	20,579.20
30-RATIO LAB PROCS/VISITS	†SD1	+ 6.25	0.16	0.14	0.14	0.13	0.13
31-OTHER DIAG. PROCEDURES		- 18.19	239.00	312.00	564.00	546.00	517.00
32-PMTS FOR OTHER DIAG. PROCS		- 7.93	7,095.11	9,315.13	12,540.62	10,027.57	10,676.79
33-RATIO OTHER DIAG. PROCS/VSIS	†SD1	+ 0.00	0.02	0.02	0.03	0.02	0.02
34-PCT INCOME - DIAG SVCS	†SD1	+ 9.96	5.29	4.78	4.88	4.47	4.73
35-NUMBER OF CONSULTATIONS	†5	- 5.27	57.00	59.00	71.00	81.00	66.00
36-PAYMENTS FOR CONSULTATIONS		- 2.26	4,311.48	4,396.89	4,598.36	5,279.70	4,364.27
37-AVG PAYMENT/CONSULTATION	†SD1	+ 9.00	75.64	73.67	64.76	65.11	66.12
38-NO. PSYCH VISITS/PSYCH RECIP	†SD1	+ 21.26	10.90	11.89	11.77	9.82	2.06
39-NO. ALL OTHER SERVICES		- 6.98	5,952.00	8,605.00	8,719.00	9,113.00	8,553.00
40-PAYMENTS FOR ALL OTHER SERVICES		- 13.33	94,309.90	150,379.06	193,217.39	192,457.28	181,504.07

FYTD TOTALS TITLE XIX SVCS 46177 BILLED 1,960,242.78 ALLOWED 1,180,211.77 PAID 1,180,888.06 PCT/PAID/BILLED 60.24
TITLE XVIII 158 4,099.35 732.23 732.23 17.86

TN # 97-005 Approval Date: 6-4-97
Supersedes
TN # 96-003 Effective Date: 7-1-97

ID-9-HUGR325S-7 — MEDICAL SERVICES ANALYSIS FOR IDAHO MEDICAID — PAGE NO. 1

RUN DATE - 01/08/97 — PROVIDER PEER GROUP SUMMARY PROFILE REPORT — PERIOD - OCT 95 DEC 96

CATEGORY OF SERVICE - 7 - PHYSICIAN EXTENDERS

REPORT--LOCALITY - IDA - IN STATE — TYPE - X52 - PHYSICIAN EXTENDERS — SPECIALTY - X01 - GP, NURSE, & PHYS. ASS'T

REFERENCE PERIOD - JUL 96-SEP 96 — FYTD PERIOD - JUL 96-DEC 96 — REFERENCE PERIOD PEER GROUP COUNT - 116

----------ACTIVITY SUMMARY----------		TREND	OCT 96 DEC 96	JUL 96 SEP 96	APR 96 JUN 96	JAN 96 MAR 96	OCT 95 DEC 95
NUMBER OF PROVIDERS REPORTING			93	116	113	113	105
NUMBER OF DIFFERENT PATIENTS			3,263	4,517	4,541	4,351	5,231
01-VOLUME SUMMARY SECTION							
02-AMOUNT BILLED - MEDICAID		- 5.76	270,809.03	434,229.70	445,818.28	380,789.92	409,287.70
03-AMOUNT PAID - MEDICAID	†10%	- 7.99	139,812.64	223,109.26	212,083.29	205,187.95	228,871.68
04-PAID AS PCT OF BILLED		2.11	51.62	51.38	47.57	53.88	55.91
05-AMOUNT PAID - MEDICARE		- 31.06	520.40	1,751.57	2,604.76	5,221.27	2,772.72
06-PAID - MEDICAID & MEDICARE		- 8.25	140,332.04	224,860.83	214,688.25	210,409.22	231,644.40
07-RECIPIENTS SERVED - XIX	†50%	- 8.11	3,375.00	4,713.00	4,838.00	4,533.00	5,312.00
08-RECIPIENTS SERVED - XVIII	†50%	- 34.98	51.00	135.00	163.00	214.00	310.00
09-RECIPIENTS SERVED - TOTAL		- 9.10	3,426.00	4,846.00	5,000.00	4,745.00	5,620.00
10-AVG. PAYMENT/RECIPIENT	†SD1	- 0.20	41.92	47.33	43.83	45.26	43.08
1 -RELATIONAL SUMMARY SECTION							
2-NO. SERVICES PROVIDED		- 8.99	6,886.00	10,497.00	10,372.00	10,064.00	11,540.00
3-AVG. NO. SERVICES/RECIPIENT	†SD1	- 1.20	2.01	2.22	2.14	2.22	2.17
4-AVG. PAYMENT/SERVICE	†SD1	+ 0.89	20.30	21.25	20.44	20.38	19.83
5-AVG CHG OFFICE SVCS/RECIP	†50%	- 2.10	40.37	38.68	43.41	43.98	42.91
6-AVG CHG OFFICE SVCS/VISIT	†50%	+ 1.83	47.61	49.39	48.86	45.72	45.09
7-PCT EXTENDED VISITS	†50%	+ 3.31	4.06	7.08	6.86	5.15	4.39
8-SVCS PER TOT REC - OFF VISIT	†50%	- 1.05	0.06	0.78	0.88	0.94	0.95
19- - FAM PLANNING	†50%	+ 0.00	0.00	0.00	0.00	0.00	0.00
20- - LAB	†50%	- 2.19	0.11	0.16	0.15	0.15	0.13
21- - LAB/REC	†50%	- 9.80	1.25	1.97	1.43	1.61	1.53
22- - XRAY	†50%	+ 0.00	0.00	0.00	0.00	0.00	0.00
23- - XRAY/REC	†50%	- 75.00	0.00	0.00	0.00	1.00	1.00
24- - INJECTIONS	†50%	- 11.11	0.06	0.01	0.03	0.06	0.08
25- - INJ/REC	†50%	+ 1.46	1.58	1.89	2.03	2.07	1.36
26- - ER VISITS	†50%	- 20.00	0.02	0.03	0.05	0.05	0.05
27- - EPSDT	†50%	+ 0.00	0.00	0.00	0.00	0.00	0.00
28- - OTHER	†50%	- 15.00	0.01	0.02	0.02	0.03	0.02
29-CHG PER REC - ALL SVCS	†50%	+ 1.70	80.23	92.13	92.14	84.00	77.04
30- - LTCF	†50%	+ 0.00	0.00	0.00	0.00	0.00	0.00
31-PCT OF TOTAL INCOME-OFF VSTS	†50%	- 2.73	57.41	46.41	55.10	56.76	59.75
32- - LTCF	†50%	- 17.15	0.05	0.05	0.16	0.09	0.12
33- - ER	†50%	- 16.69	2.88	3.86	5.39	5.31	6.08
34- - HOME VSTS	†50%	- 40.00	0.00	0.00	0.01	0.04	0.00
35- - EPSDT	†50%	+ 0.00	0.00	0.00	0.00	0.00	0.00

FYTD TOTALS TITLE XIX	SVCS	17383	BILLED	705,038.73	ALLOWED	355,867.79	PAID	362,921.90	PCT/PAID/BILLED 51.47
TITLE XVIII		299		13,102.90		2,273.86		2,271.97	17.33

TN # 97-005 Approval Date: 6-4-97

Supersedes

TN # 96-003 Effective Date: 7-1-97

5. a. vi. Adequacy of Access - Pediatrics: Analysis of MMIS provider participation for designated provider classes indicate the maximum allowed fees in effect since 7/1/96 were successful in providing recipients' access. The maximum allowed fees submitted for effect 7/1/97 are expected to be more than adequate to assure access equal to that obtained by the general public. Analysis of charge data for the most recently completed 12 month period was completed for confirmation purposes.

5. a. vii. Inflation Adjustment, per new section of Idaho Code, Chapter 1, Title 56, Section 136: (1) Beginning with fiscal year 1996, the rate of reimbursement for all Medicaid-covered physician services rendered to Medicaid recipients shall be adjusted each fiscal year. Each fiscal year adjustment shall be determined by the Director, and shall equal the year over year inflation rate forecasted as of the midpoint of the fiscal year by the index of all items, goods and services in the pacific northwest as published by Data Resources Incorporated. Such forecast index shall be the last published forecast prior to the start of the fiscal year, provided, however, an adjustment may exceed the index rate sited in this section at the discretion of the Legislature.

5. b. Dentists - Payment is made according to the maximum allowable payments as established by the Department, as if the service was furnished by a physician in Attachment 4.19-B 5.a. Physicians.

6. a. Podiatrists - Payment for the care and treatment of acute foot conditions by podiatrists will be determined in the same manner as physicians in Attachment 4.19-B 5.a. Physicians.

b. Optometrists - The Department observes the fee assigned to CPT procedure codes 92002 through 92014 as the upper limit of payment fro examinations for visual acuity by optometrists. For practitioners who are certified to treat and diagnose disease and injuries of the eye, payment will be limited to that level paid to a physician for the same service.

c. Chiropractors - The Department's upper limit for reimbursement is the lower of:

i. The chiropractor's actual charge; or

ii. The allowable charge as established by the Department fee schedule.

d. Other Practitioner Services -

i. Physician Assistants - The rate of payment for these providers will be at the maximum payment level established by the Department or the amount billed, whichever is less. These providers will use the identical procedure codes as physicians.

ii. Certified Registered Nurse Anesthetists (CRNA) - The rate of payment for these providers will be at the maximum level established by the Department or the amount billed, whichever is less. These providers will use the identical anesthesia procedure codes as physicians.

7. Home Health Services

a. Nursing services – Payment can not exceed the lesser of reasonable cost as determined by Medicare or the Title XIX percentile cap, which is established at the seventy-fifth percentile of the ranked costs per visit, as determined by the Departments of the Ranked costs per visit, as determined by the by the Department's Medical Assistance Unit using the data from the most recent finalized Medicare cost reports. The percentile cap will be revised annually. the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to effective date.

b. Home Health Aide-Payment can not exceed the lesser of the reasonable cost as determined by Medicare or the Title XIX percentile cap, which is established at the seventy fifth percentile of the ranked costs per visit, as determined by the Departments Medical Assistance Unit using the data from the most recent finalized Medicare cost reports. The percentile cap will be revised annually. Effective at the beginning of each state fiscal year, revisions will be made using the data from the most recent finalized Medicare cost reports on hand, thirty (30) days prior to effective date.

c. Equipment and Supplies

i Equipment and Supplies provided by a Home Health Agency - When determining reasonable cost of rental medical equipment ordered by the physician and used for the care of the patient, the monthly rental cost of a Durable Medical Equipment (DME) item shall not exceed one tenth (1/10) of the total purchase price of the item, unless this amount is less than $15.00. A minimum rental rate of fifteen dollars ($15.00) per month is allowed on all DME items.

The Department's Medical Assistance Unit may enter in a lease /purchase agreement with a home health agency to purchase medical equipment when rental charge totals the purchase price of the equipment.

For purchase of supplies the Department's Medical Assistance Unit will not pay more than the lower of: the providers usual and customary charge for the supplies; or the maximum allowable charge for these services as established by the Departments Medical Assistance Unit; or the Medicare upper limitation of payment on these items where a beneficiary is eligible under both programs and Medicaid is responsible only for the deductible and coinsurance payment.

ii Medical Equipment and Supplies not Associated with a Home Health Agency and Provided by Medical Equipment Supplier – The Department's Medical Assistance Unit will not pay the individual provider more than the lowest of: the providers usual and customary charge for service; or the maximum allowable charge for the item as established by the Department's Medical Assistance Unit on its pricing file; or the Medicare upper limitation of payment on the item where

the beneficiary is eligible under both programs and Medicaid is responsible only for the deductible and coinsurance payment. Durable Medical Equipment (DME) Rental - the monthly rental amount shall not exceed one tenth (1/10th) of the Total purchase price of the item unless this amount is less than $15.00. A minimum rental rate of fifteen($15.00) per month is allowed on all DME items.

iii. Medical Gases - Payment s are limited to the rates established by the Department' s Medical Assistance Unit.

iv. Assistive and Augmentative Communication Devices are covered as a Durable Medical Equipment item, and would not be billable under speech therapy or as a prosthetic.

d. Home Health Agency - Payment for Physical therapy and Occupational therapy provided by an agency, payment can not exceed the lesser of reasonable cost as determined by Medicare or the Title XIX percentile cap, which is established at the 75th percentile of the ranked costs per visit, as determined by the Department's Medical Assistance Unit using the data from the most recent finalized Medicare cost reports. The percentile cap will be revised annually. Effective at the beginning of each state fiscal year, revisions will be made using the data from the most recent finalized Medicare cost reports on hand, thirty (30) days prior to effective date.

9. a. Clinic Services

i. Mental Health Clinics – The Department's Medical Assistance upper limit for reimbursement is the lower of: the mental health clinic's actual charge; or the allowable charge as established by the Department's Medical Assistance fee schedule.

ii. Ambulatory Surgical Centers – The Department's Medical Assistance Unit reimburses for the use of facilities and supplies at the rural payment level established by the Medicare Part B Carrier for the State of Idaho. Any surgical procedure identified by the Department's Medical Assistance Unit for which a payment level will be reimbursed at a rate established by the Department's Medical Assistance Unit.

iii. Diagnostic Screening Clinics – Clinic services are available only through those medical facilities which have a specific contract or agreement with the Department's Medical Assistance Unit. A specific fee schedule is required and prior authorization for certain services may be delineated in the contract as well as other limitations set by the state agency and subject to the provisions of 42 CFR 447.321.

iv. Indian Health Clinics – Payment for Indian Health Service (HIS)/tribal 638 outpatient services is made at the most current outpatient per visit rate published by IHS in the Federal Register.

v. Diabetes Education and Training Clinics – Diabetic education and training services are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule.

10. Dentists - Payments are made to participating dentists on the basis of the lower of: actual charges; or the Department's Medical Assistance Unit statewide fee schedule.

11. Physical Therapy - Payments for physical therapy services provided by independent physical therapists are limited to the rates established by the Department's Medical Assistance Unit, but will not exceed the upper limits of Medicare.

12. a. Prescription Drugs:

i. Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program.

ii. Reimbursement for all covered drugs shall be limited to the lowest of the following:
   a) Federal Upper Limit (FUL) as established by CMS, plus the dispensing fee assigned by the Department.
   b) State Maximum Allowable Cost (SMAC) as established by the Department, plus the assigned dispensing fee.
   c) Estimated Acquisition cost (EAC)
      i) Defined as the Average Wholesale Price (AWP) minus 12% plus the assigned dispensing fee.
   d) The provider's usual and customary charge to the general public.

iii. Dispensing Fee:
The dispensing fee shall be one of two types:
   a) Regular dose fee is $4.94 per prescription.
   b) Unit dose fee is $5.54 per prescription, and is defined as a system of providing individually sealed and appropriate labeled unit dose medication that ensures no more than a 24 hour supply in any client's drug tray at any given time. These trays shall be delivered to the facility at least five days per week.

iv. Supplemental Rebate Agreement:
Based on the requirements in Section 1927 of the Act, the state has the following policies for the supplemental drug rebate program for Medicaid recipients:
   a) The model rebate agreement between the state and drug manufacturers for drugs provided to Medicaid recipients, submitted to CMS on April 23, 2004 and entitled "Supplemental Rebate Agreement " has been authorized by CMS.
   b) The model rebate agreement between the state and drug manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 27, 2004 and entitled "Merck Agreement" has been authorized by CMS.
   c) Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
   d) Manufacturers are allowed to audit utilization rates.

e) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with 1927 (b) (3) (D).
f) Payment of a supplemental rebate may not exempt a drug from prior authorization. It is one factor but is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, and the net economic impact of inclusion or exclusion of the drug from prior authorization.
g) Manufacturers who do not participate in the supplemental rebate program will have their drugs made available to Medicaid beneficiaries through the prior authorization process.

SUPPLEMENTAL REBATE AGREEMENT

This Supplemental Rebate Agreement (Agreement) is by and between the **State of Idaho Department of Health and Welfare** (State) and _____ (Provider).

RECITALS

WHEREAS, the State has the authority to enter into agreements with pharmaceutical manufacturers to collect supplemental rebates for the benefit of the State's Medicaid recipients providing such agreements are authorized by the Centers for Medicare and Medicaid Services (CMS); and

WHEREAS, the Provider is willing to provide supplemental rebates to the State based on the actual dispensing of Provider Covered Products under the State's Medicaid program.

NOW THEREFORE, in consideration of the foregoing and of the representations, warranties and covenants set forth below, the parties, intending to be legally bound, agree as follows:

1. **Definitions**. As used herein, the following terms shall have the meanings set forth below:

1.1 **Agreement** means this Supplemental Rebate Agreement, including all documents attached or incorporated by reference.

1.2 **Average Manufacturer Price (AMP)** shall mean, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

1.3 **Average Wholesale Price (AWP)** shall mean the published price of the Covered Product by National Drug Code (NDC) as published by First DataBank on the first day of the calendar quarter that corresponds to the calendar quarter for which the State utilization data for the Covered Product is reported to the Provider.

1.4 **Basic Rebate** shall mean, with respect to the Covered Product, the quarterly payment by the Provider pursuant to the Provider's Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act (42 U.S.C. 1396r-8(c)(1) and 42 U.S.C. 1396r-8 (c)(3)).

1.5 **Best Price** shall mean the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity with the exception of those exceptions stated at Section 1927 (c)(1)(C).

1.6 **CMS** shall mean the Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) of the U.S. Department of Health and Human Services (HHS), or any successor or renamed agency carrying out the functions and duties heretofore carried out by such office.

1.7 **Competitive Product** shall mean a pharmaceutical product that is therapeutically interchangeable to one or more Covered Products of Provider.

1.8 **Covered Product** shall mean a pharmaceutical product identified in Attachment A of this Agreement.

1/1/04

1.9 **CPI Rebate** means, with respect to the Covered Product, the quarterly payment by the Provider pursuant to the Provider's Medicaid Drug Rebate Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. § 1396r-8(c)(2).

1.10 **IDAPA** means the Idaho Administrative Procedures Act. All references in this Agreement to IDAPA chapters or sections shall include any successor, amended, or replacement rule.

1.11 **Ingredient Reimbursement Basis** shall mean the formula used by State to reimburse Pharmacy providers for branded pharmaceuticals.

1.12 **Maximum Allowable Cost (MAC)** shall mean the lowest reimbursement rate established by the State for Covered Product.

1.13 **Medicaid Drug Rebate Agreement** shall mean the agreement in place between the Provider and the Secretary of Health and Human Services, pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). CMS is the agency within HHS having the delegated authority to operate the Medicaid program.

1.14 **Medicaid Recipient** shall mean any person enrolled in the State Medicaid Program and eligible to receive prescription drug benefits under a fee for service arrangement.

1.15 **Net Cost** shall mean the prescription drug ingredient reimbursement calculated as provided in IDAPA 16.03.09.817.04 minus the sum of all rebates paid by the Provider to the State for the Covered Product for the calendar quarter. In the event of any change to the calculation used by the State to determine drug ingredient reimbursement paid by the State to Pharmacy providers, the applicable terms of this Agreement shall be amended to reflect such change.

1.16 **Pharmacy** shall mean a facility licensed to dispense legend drugs and enrolled as a State Medicaid provider.

1.17 **Prior Approval Process** shall mean a process by which the State Medicaid Program approves prior to dispensing various pharmaceutical products for the purpose of guiding the prescribing, dispensing and acquisition of pharmaceutical products covered by the State Medicaid Program.

1.18 **State Medicaid Program** shall mean the joint federal and state medical assistance program as established and defined pursuant to Title 42 U.S.C. 1396, et seq., that provides reimbursement for or coverage of prescription drug products to Medicaid Recipients.

1.19 **State Supplemental Rebate** shall mean an amount paid on a calendar quarter basis by the Provider to the State for utilization under State's fee for service Medicaid program pursuant to the Rebate Formula in Attachment B of this Agreement.

1.20 **Unit** means drug unit in the lowest identifiable amount (e.g., tablet or capsule or solid dosage forms, milliliter for liquid forms, gram for ointment or creams).

1.21 **USC** means the United States Code. All references in this agreement to USC chapters or sections shall include any successor, amended, or replacement statute.

1/1/04

2. **State Obligations**

2.1 **Status Under Prior Approval Process.** To be eligible for the Supplemental Rebates specified in Attachment B, State shall grant Covered Product the status under the Prior Approval Process described in Attachment B, it being agreed that utilization shall be eligible for the State Supplemental Rebate only in quarters in which Covered Product holds the status under the Prior Approval Process described in Attachment B.

2.2 **Prior Approval Process Status Publication.** State shall communicate the status of Covered Product to State Medicaid Program providers through the standard notification process.

2.3 **Invoicing.** State shall invoice Provider for State Supplemental Rebates separately from CMS Rebates using the format set forth by CMS (Reconciliation of State Invoice format). State shall submit the State Supplemental Rebate invoice to the Provider within sixty (60) days after the end of each calendar quarter in which the Covered Product subject to such State Supplemental Rebate was paid for by State. Any amended invoice shall be submitted by State within fifteen (15) months after the end of the calendar quarter in which Covered Product was paid for by State.

2.4 **Patient Information.** State, its agents, employees and contractors shall not provide to the Provider any patient identifiable information or protected health information (PHI) or any other information prohibited or regulated by laws or regulations governing confidentiality of medical or other information.

2.5 **Approval of Generic Equivalent.** If during the duration of this Agreement a generic equivalent of any Competitive Product should become available, State will allow Covered Product to retain the status set forth in Attachment B so long as the net cost to the State, as defined in Attachment B, is not more than the lowest reimbursement cost as established by IDAPA 16.03.09.817.04 for a generic equivalent.

3. **Provider Obligations**

3.1 **State Supplemental Rebate Payment**. Provider agrees to provide a State Supplemental Rebate for each of its Covered Products that is paid for by the State and dispensed to Medicaid Recipients by Pharmacies for each calendar quarter that Covered Products retain the status under the Prior Approval Process set forth in Attachment B. Provider shall pay to State the State Supplemental Rebate amount in accordance with the formula set forth in Attachment B. State shall remit the appropriate share of the State Supplemental Rebate payments made under the Agreement to CMS as required under its approved state plan. Nothing in this Agreement shall be construed to relieve the Provider from its obligation to pay Basic Rebates to State pursuant to the Medicaid Drug Rebate Agreement.

3.2 **Payment Timeframe.** Provider shall pay to State the State Supplemental Rebate amount to which State is entitled in accordance with the formula set forth in Attachment B, within thirty-eight (38) days of Provider's receipt of the State Supplemental Rebate invoice pursuant to Section 2.3.

3.3 **Incomplete Submission.** Provider shall have no obligation to pay State Supplemental Rebate amounts for claims that are not submitted as part of an invoice in accordance with Section 2.3 of this Agreement. Provider shall notify State or its designee of any incomplete submission within thirty-eight (38) days after Provider's receipt of such submission pursuant to Section 2.3.

1/1/04

3.4 **Over/Underpayment.** If either party discovers an error in the payment of State Supplemental Rebates, it shall notify the other of such error. The parties shall attempt to reconcile all differences through discussion and negotiation; if that attempt fails, the parties will resolve their dispute in accordance with generally accepted applicable procedures followed by State or CMS in disputes concerning Medicaid Drug Rebates. Any overpayment shall be deducted from subsequent State Supplemental Rebates payable under this Agreement. In the event that no subsequent State Supplemental Rebates are payable, State will refund any such overpayment to Provider within thirty (30) days of the parties' acknowledgement of the overpayment. Provider will remit any underpayment to State within thirty (30) days of the parties' acknowledgement of such underpayment.

3.5 **Discretion to Market.** Nothing in this Agreement shall be construed to prohibit the Provider from discontinuing production, marketing or distribution of any Covered Product or from transferring or licensing any Covered Product to a third party. It is understood that the Provider is liable for the payment of State Supplemental Rebates only for Covered Products (as identified by the 11-digit NDC code) distributed (directly or through the wholesale channel) to retail Pharmacies and dispensed to Medicaid Recipients. If the Provider elects to discontinue production, marketing or distribution of any Covered Product or to transfer or license any Covered Product to a third party, the Provider shall make every reasonable effort to notify the State prior to such actions.

4. Term and Termination

4.1 **Effective Date.** This agreement shall be effective as of _____, and shall continue in force through _____, unless it is terminated sooner pursuant to the following:

a) **Breach.** If either party commits a material breach of this agreement, the non-breaching party shall deliver written notice mailed by certified mail, return receipt requested, of the alleged breach to the breaching party, with an opportunity for the breaching party to cure the breach during the thirty (30) day period following the delivery. Failure to cure shall give the non-breaching party the right to cancel this agreement at the end of the thirty (30) day period. The non-breaching party shall give the breaching party final written notice of the cancellation of this agreement.

b) **Without Cause.** Either party may terminate this Agreement without cause as of the end of any calendar quarter by giving the other party sixty (60) days prior written notice.

4.2 **Accrued Obligations/Remedies.** The expiration or termination of this Agreement shall not affect any rights or obligations of the parties that have accrued prior to the effective date of such termination. The fact that either party exercises any right of termination it may have under this Agreement shall not prevent such party from pursuing any other remedy it may be entitled to in law or equity. Any remedy provided herein shall not be deemed an exclusive remedy unless expressly provided for as such.

4.3 **Execution, Amendment, and Waiver.** This Agreement shall be binding only upon signature by both parties. This Agreement, or any provision, may be altered, amended, or waived by a written amendment executed by both parties as authorized by CMS.

1/1/04

5. **Miscellaneous**

5.1 **Record Keeping and Audit.** During the term of this Agreement and for a period of five (5) years thereafter, both parties to the Agreement shall use reasonable efforts at all times to ensure that they maintain accurate books, files and records relevant to this Agreement. At Provider's written request, State shall make such information available for inspection by Provider representatives or its designated auditors during regular business hours. Upon written request, each party shall otherwise have the right to inspect, up to once each year, all such relevant books and records of the other party to verify compliance with the terms of this Agreement.

5.2 **Indemnification.** Provider shall be responsible for and shall indemnify and hold State harmless from all claims caused by or arising out of Provider's or any subcontractor's negligent or otherwise wrongful performance, act or omission under the Agreement. Nothing in this provision shall extend Provider's and any subcontractor's indemnification of the State beyond the liability of the Department provided in the Idaho Tort Claim's Act, Idaho Code Section 6-901 *et seq.*, the aggregate of which is limited by Idaho Code Section 6-926. State shall be responsible and shall indemnify and hold Provider harmless from all claims caused by or arising out of the State's negligent or otherwise wrongful performance, act, or omission of any term of the Agreement. Nothing in this provision shall extend the liability of the State beyond that provided in the Idaho Tort Claims Act, Idaho Code Section 6-901 *et seq*.

5.3 **Confidentiality.** Except as otherwise may be required to be disclosed by law and in accordance with the Medicaid Drug Rebate Agreement between the Secretary of U.S. Department of Health and Human Services and the drug manufacturers, information disclosed by Provider in connection with this Agreement will not be unnecessarily disclosed by the State. Each party shall maintain the confidentiality of all the terms and conditions of this Agreement throughout the term hereof and for a period of three (3) years thereafter.

5.4 **Notices.** Any notice required or permitted to be given by either party to the other shall be given in person or sent by first class mail or express delivery, addressed to the other party at the address set forth below.

State Mailing Address:
Laura Windham, Contracts Supervisor
Idaho Dept. of Health and Welfare
Division of Medicaid
Bureau of State Operations
P.O. Box 83720
Boise, ID 83720-0036

Provider Mailing Address:
_____
_____
_____
_____
_____

5.5 **Force Majeure.** Noncompliance with any obligations hereunder due to force majeure, such as acts of God, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the parties, shall not constitute breach of contract.

1/1/04

5.6 **Assignment.** Neither party shall have the right to assign this Agreement to a third party without the prior written consent of the other party, which consent shall not be unreasonably withheld. Any permitted assignee shall assume all obligations of its assignor under this Agreement. No assignment shall relieve any party of responsibility for the performance of any obligations that have accrued prior to such assignment.

5.7 **No Waiver of Rights.** The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy in the future. Every right and remedy given by this Agreement to the parties may be exercised from time to time as often as appropriate.

5.8 **Entire Agreement.** This Agreement contains the entire agreement and understanding of the parties. This Agreement (including Attachments) may not be amended or modified except upon the written agreement of both parties as authorized by CMS.

5.9 **Governing Law.** This Agreement shall be governed by the laws of the State of Idaho. In the event of a lawsuit involving this Agreement, venue shall be proper only in Ada County, Idaho.

5.10 **Effect of Future Laws or Interpretations of Law.** In the event of the enactment, promulgation, rescission, modification or interpretation of any law or regulation after the date hereof which would

(a) materially adversely affect the manner in which either party is obligated to perform under this Agreement,

(b) adversely affect for either party the net prices or State Supplemental Rebates or other terms applicable under this Agreement, or

(c) have the effect of requiring the net prices or State Supplemental Rebates or other terms applicable under this Agreement to be extended or offered to any third party,

Each party shall have the right to enter into good faith negotiation with the other in order to seek to agree on reasonable terms for maintaining the intent of the Agreement affected by such enactment, promulgation, etc. Agreement on any such terms shall be in the sole discretion of each party. If the parties do not agree within thirty (30) days of a party's written request for negotiations, either party may terminate this Agreement with respect to the affected Covered Products upon expiration of the thirty (30) day period, with immediate effect.

5.11 **Compliance with Law.** In connection with its respective obligations under this Agreement, each party shall comply with all applicable federal, state and local laws and regulations, including without limitation any disclosure or consent requirements.

5.12 **Authority.** State and Provider each represent and warrant to the other that the person signing below has all requisite legal power and authority to execute this Agreement on behalf of each party and each party shall thereby be bound.

5.13 **Best Price Contingency.** The effectiveness of this Agreement shall be contingent on Provider's Best Price and AMP not being affected by State Supplemental Rebates.

1/1/04

5.14 **CMS Approval Contingency.** The effectiveness of this Agreement shall be contingent on receipt by State of CMS approval of the state plan amendment which authorized the form of this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed by the parties set forth below:

State of Idaho
Department of Health and Welfare
Division of Medicaid

By: _____ **Date**_____
David A. Rogers
Administrator

_____

By: _____ **Date**_____

_____

_____

1/1/04

ATTACHMENT A

Covered Products

The products to which this Supplemental Rebate Agreement shall apply are the following:

NDC	Brand	Strength	Package Description

1/1/04

ATTACHMENT B

Rebate Formula

Supplemental Rebate shall be calculated on a calendar quarter basis according to the following formula and will be lower than or equal to the net cost of the Competitive Product:

Supplemental Rebate =([1]Ingredient Reimbursement) – ([2]CMS Rebate) - (Net Cost)

First Quarter 2002 net cost for (name of product):
Net Cost for (name/dosage of product) = (price)
Net Cost for (name/dosage of product) = (price)

---

[1] Ingredient Reimbursement based on the Average Wholesale Price (AWP) as published by First DataBank on the first day of a calendar quarter for the quarter in which the rebate applies;

[2] CMS Rebate as calculated and provided to State by CMS on a calendar quarter for the quarter in which the rebate applies.

1/1/04

Supplemental Rebate Agreement

This Supplemental Rebate Agreement (Agreement) is by and between the **State of Idaho Department of Health and Welfare** (State) and **Merck & Co., Inc.** (Provider).

RECITALS

WHEREAS, the State has the authority to enter into agreements with pharmaceutical manufacturers to collect supplemental rebates for the benefit of the State's Medicaid recipients providing such agreements are authorized by the Centers for Medicare and Medicaid Services (CMS); and

WHEREAS, the Provider is willing to provide supplemental rebates to the State based on the actual dispensing of Provider Covered Products under the State's Medicaid program.

NOW THEREFORE, in consideration of the foregoing and of the representations, warranties and covenants set forth below, the parties, intending to be legally bound, agree as follows:

1. **Definitions**. As used herein, the following terms shall have the meanings set forth below:

1.1 **Agreement** means this Supplemental Rebate Agreement, including all documents attached or incorporated by reference.

1.2 **Average Manufacturer Price (AMP)** shall mean, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

1.3 **Average Wholesale Price (AWP)** shall mean the published price of the Covered Product by National Drug Code (NDC) as published by First DataBank on the first day of the calendar quarter that corresponds to the calendar quarter for which the State utilization data for the Covered Product is reported to the Provider.

1.4 **Basic Rebate** shall mean, with respect to the Covered Product, the quarterly payment by the Provider pursuant to the Provider's Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(I) or Section 1927(c)(3) of the Social Security Act (42 U.S.C. 1396r-8(c)(I) and 42 U.S.C. 1396r-8(3)).

1.5 **Best Price** shall mean the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity with the exception of those exceptions stated at Section 1927 (c)(1)(C).

1.6 **CMS** shall mean the Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) of the U.S. Department of Health and Human Services (HHS), or any successor or renamed agency carrying out the functions and duties heretofore carried out by such office.

1.7 **Competitive Product** shall mean a pharmaceutical product that is therapeutically interchangeable to one or more Covered Products of Provider.

1/1/04

1.8 **Covered Product** shall mean a pharmaceutical product identified in Attachment A of this Agreement.

1.9 **CPI Rebate** means, with respect to the Covered Product, the quarterly payment by the Provider pursuant to the Provider's Medicaid Drug Rebate Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. § 1396r-8(c)(2).

1.10 **IDAPA** means the Idaho Administrative Procedures Act. All references in this Agreement to IDAPA chapters or sections shall include any successor, amended, or replacement rule.

1.11 **Ingredient Reimbursement Basis** shall mean the formula used by State to reimburse Pharmacy providers for branded pharmaceuticals.

1.12 **Maximum Allowable Cost (MAC)** shall mean the lowest reimbursement rate established by the State for Covered Product.

1.13 **Medicaid Drug Rebate Agreement** shall mean the agreement in place between the Provider and the Secretary of Health and Human Services, pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). CMS is the agency within HHS having the delegated authority to operate the Medicaid program.

1.14 **Medicaid Recipient** shall mean any person enrolled in the State Medicaid Program and eligible to receive prescription drug benefits under a fee for service arrangement.

1.15 **Net Cost** shall mean the prescription drug ingredient reimbursement calculated as provided in IDAPA 16.03.09.817.04 minus the sum of all rebates paid by the Provider to the State for the Covered Product for the calendar quarter. In the event of any change to the calculation used by the State to determine drug ingredient reimbursement paid by the State to Pharmacy providers, the applicable terms of this Agreement shall be amended to reflect such change.

1.16 **Pharmacy** shall mean a facility licensed to dispense legend drugs and enrolled as a State Medicaid provider.

1.17 **Prior Approval Process** shall mean a process by which the State Medicaid Program approves prior to dispensing various pharmaceutical products for the purpose of guiding the prescribing, dispensing and acquisition of pharmaceutical products covered by the State Medicaid Program.

1.18 **State Medicaid Program** shall mean the joint federal and state medical assistance program as established and defined pursuant to Title 42 U.S.C. 1396, et seq., that provides reimbursement for or coverage of prescription drug products to Medicaid Recipients.

1.19 **State Supplemental Rebate** shall mean an amount paid on a calendar quarter basis by the Provider to the State for utilization under State's fee for service Medicaid program pursuant to the Rebate Formula in Attachment B of this Agreement.

1.20 **Unit** means drug unit in the lowest identifiable amount (e.g., tablet or capsule or solid dosage forms, milliliter for liquid forms, gram for ointment or creams).

1/1/04

1.21 **USC** means the United States Code. All references in this agreement to USC chapters or sections shall include any successor, amended, or replacement statute.

2. State Obligations

2.1 **Status Under Prior Approval Process.** To be eligible for the Supplemental Rebates specified in Attachment B, State shall grant Covered Product the status under the Prior Approval Process described in Attachment B, it being agreed that utilization shall be eligible for the State Supplemental Rebate only in quarters in which Covered Product holds the status under the Prior Approval Process described in Attachment B.

2.2 **Prior Approval Process Status Publication.** State shall communicate the status of Covered Product to State Medicaid Program providers through the standard notification process.

2.3 **Invoicing.** State shall invoice Provider for State Supplemental Rebates separately from CMS Rebates using the format set forth by CMS (Reconciliation of State Invoice format). State shall submit the State Supplemental Rebate invoice to the Provider within sixty (60) days after the end of each calendar quarter in which the Covered Product subject to such State Supplemental Rebate was paid for by State. Any amended invoice shall be submitted by State within fifteen (15) months after the end of the calendar quarter in which Covered Product was paid for by State.

2.4 **Patient Information.** State, its agents, employees and contractors shall not provide to the Provider any patient identifiable information or protected health information (PHI) or any other information prohibited or regulated by laws or regulations governing confidentiality of medical or other information.

2.5 **Approval of Generic Equivalent.** If during the duration of this Agreement a generic equivalent of any Competitive Product should become available, State will allow Covered Product to retain the status set forth in Attachment B so long as the net cost to the State, as defined in Attachment B, is not more than the lowest reimbursement cost as established by IDAPA 16.03.09.817.04 for a generic equivalent.

3. Provider Obligations

3.1 **State Supplemental Rebate Payment**. Provider agrees to provide a State Supplemental Rebate for each of its Covered Products that is paid for by the State and dispensed to Medicaid Recipients by Pharmacies for each calendar quarter that Covered Products retain the status under the Prior Approval Process set forth in Attachment B. Provider shall pay to State the State Supplemental Rebate amount in accordance with the formula set forth in Attachment B. State shall remit the appropriate share of the State Supplemental Rebate payments made under the Agreement to CMS as required under its approved state plan. Nothing in this Agreement shall be construed to relieve the Provider from its obligation to pay Basic Rebates to State pursuant to the Medicaid Drug Rebate Agreement.

3.2 **Payment Timeframe.** Provider shall pay to State the State Supplemental Rebate amount to which State is entitled in accordance with the formula set forth in Attachment B, within thirty-eight (38) days of Provider's receipt of the State Supplemental Rebate invoice pursuant to Section 2.3.

1/1/04

3.3 **Incomplete Submission.** Provider shall have no obligation to pay State Supplemental Rebate amounts for claims that are not submitted as part of an invoice in accordance with Section 2.3 of this Agreement. Provider shall notify State or its designee of any incomplete submission within thirty-eight (38) days after Provider's receipt of such submission pursuant to Section 2.3.

3.4 **Over/Underpayment.** If either party discovers an error in the payment of State Supplemental Rebates, it shall notify the other of such error. The parties shall attempt to reconcile all differences through discussion and negotiation; if that attempt fails, the parties will resolve their dispute in accordance with generally accepted applicable procedures followed by State or CMS in disputes concerning Medicaid Drug Rebates. Any overpayment shall be deducted from subsequent State Supplemental Rebates payable under this Agreement. In the event that no subsequent State Supplemental Rebates are payable, State will refund any such overpayment to Provider within thirty (30) days of the parties' acknowledgement of the overpayment. Provider will remit any underpayment to State within thirty (30) days of the parties' acknowledgement of such underpayment.

3.5 **Discretion to Market.** Nothing in this Agreement shall be construed to prohibit the Provider from discontinuing production, marketing or distribution of any Covered Product or from transferring or licensing any Covered Product to a third party. It is understood that the Provider is liable for the payment of State Supplemental Rebates only for Covered Products (as identified by the 11-digit NDC code) distributed (directly or through the wholesale channel) to retail Pharmacies and dispensed to Medicaid Recipients. If the Provider elects to discontinue production, marketing or distribution of any Covered Product or to transfer or license any Covered Product to a third party, the Provider shall make every reasonable effort to notify the State prior to such actions.

4. Term and Termination

4.1 **Effective Date.** This agreement shall be effective as of the date of the State's signature though no earlier than January 1, 2004, and shall continue in force through December 31, 2004, unless it is terminated sooner pursuant to the following:

a) **Breach.** If either party commits a material breach of this agreement, the non-breaching party shall deliver written notice mailed by certified mail, return receipt requested, of the alleged breach to the breaching party, with an opportunity for the breaching party to cure the breach during the thirty (30) day period following the delivery. Failure to cure shall give the non-breaching party the right to cancel this agreement at the end of the thirty (30) day period. The non-breaching party shall give the breaching party final written notice of the cancellation of this agreement.

b) **Without Cause.** Either party may terminate this Agreement without cause as of the end of any calendar quarter by giving the other party sixty (60) days prior written notice.

4.2 **Accrued Obligations/Remedies.** The expiration or termination of this Agreement shall not affect any rights or obligations of the parties that have accrued prior to the effective date of such termination. The fact that either party exercises any right of termination it may have under this Agreement shall not prevent such party from pursuing any other remedy it may be entitled to in law or equity. Any remedy provided herein shall not be deemed an exclusive remedy unless expressly provided for as such.

1/1/04

4.3 **Execution, Amendment, and Waiver.** This Agreement shall be binding only upon signature by both parties. This Agreement, or any provision, may be altered, amended, or waived by a written amendment executed by both parties as authorized by CMS.

5. **Miscellaneous**

5.1 **Record Keeping and Audit.** During the term of this Agreement and for a period of five (5) years thereafter, both parties to the Agreement shall use reasonable efforts at all times to ensure that they maintain accurate books, files and records relevant to this Agreement. At Provider's written request, State shall make such information available for inspection by Provider representatives or its designated auditors during regular business hours. Upon written request, each party shall otherwise have the right to inspect, up to once each year, all such relevant books and records of the other party to verify compliance with the terms of this Agreement.

5.2 **Indemnification.** Provider shall be responsible for and shall indemnify and hold State harmless from all claims caused by or arising out of Provider's or any subcontractor's negligent or otherwise wrongful performance, act or omission under the Agreement. Nothing in this provision shall extend Provider's and any subcontractor's indemnification of the State beyond the liability of the Department provided in the Idaho Tort Claim's Act, Idaho Code Section 6-901 *et seq.*, the aggregate of which is limited by Idaho Code Section 6-926. State shall be responsible and shall indemnify and hold Provider harmless from all claims caused by or arising out of the State's negligent or otherwise wrongful performance, act, or omission of any term of the Agreement. Nothing in this provision shall extend the liability of the State beyond that provided in the Idaho Tort Claims Act, Idaho Code Section 6-901 *et seq*.

5.3 **Confidentiality.** Except as otherwise may be required to be disclosed by law and in accordance with the Medicaid Drug Rebate Agreement between the Secretary of U.S. Department of Health and Human Services and the drug manufacturers, information disclosed by Provider in connection with this Agreement will not be unnecessarily disclosed by the State. Each party shall maintain the confidentiality of all the terms and conditions of this Agreement throughout the term hereof and for a period of three (3) years thereafter.

5.4 **Notices.** Any notice required or permitted to be given by either party to the other shall be given in person or sent by first class mail or express delivery, addressed to the other party at the address set forth below.

State Mailing Address:
Laura Windham, Contracts Supervisor
Idaho Dept. of Health and Welfare
Division of Medicaid
Bureau of State Operations
P.O. Box 83720
Boise, ID 83720-0036

Provider Mailing Address:
Susan Beebe, Director CCM
Merck & Co., Inc. WP39-414
770 Sumneytown Pike
P.O. Box 4
West Point, PA 19486-0004

5.5 **Force Majeure.** Noncompliance with any obligations hereunder due to force majeure, such as acts of God, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common

11/04

carriers, and any other causes beyond the reasonable control of the parties, shall not constitute breach of contract.

5.6 **Assignment.** Neither party shall have the right to assign this Agreement to a third party without the prior written consent of the other party, which consent shall not be unreasonably withheld. Any permitted assignee shall assume all obligations of its assignor under this Agreement. No assignment shall relieve any party of responsibility for the performance of any obligations that have accrued prior to such assignment.

5.7 **No Waiver of Rights.** The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy in the future. Every right and remedy given by this Agreement to the parties may be exercised from time to time as often as appropriate.

5.8 **Entire Agreement.** This Agreement contains the entire agreement and understanding of the parties, with the sole exception that the Confidentiality Agreement effective September 30, 2003, and executed by Provider, State, and The Regence Group contains additional terms of agreement between the parties. This Agreement (including Attachments) may not be amended or modified except upon the written agreement of both parties as authorized by CMS.

5.9 **Governing Law.** This Agreement shall be governed by the laws of the State of Idaho. In the event of a lawsuit involving this Agreement, venue shall be proper only in Ada County, Idaho.

5.10 **Effect of Future Laws or Interpretations of Law.** In the event of the enactment, promulgation, rescission, modification or interpretation of any law or regulation after the date hereof which would

(a) materially adversely affect the manner in which either party is obligated to perform under this Agreement,

(b) adversely affect for either party the net prices or State Supplemental Rebates or other terms applicable under this Agreement, or

(c) have the effect of requiring the net prices or State Supplemental Rebates or other terms applicable under this Agreement to be extended or offered to any third party,

Each party shall have the right to enter into good faith negotiation with the other in order to seek to agree on reasonable terms for maintaining the intent of the Agreement affected by such enactment, promulgation, etc. Agreement on any such terms shall be in the sole discretion of each party. If the parties do not agree within thirty (30) days of a party's written request for negotiations, either party may terminate this Agreement with respect to the affected Covered Products upon expiration of the thirty (30) day period, with immediate effect.

5.11 **Compliance with Law.** In connection with its respective obligations under this Agreement, each party shall comply with all applicable federal, state and local laws and regulations, including without limitation any disclosure or consent requirements.

1/1/04

5.12 **Authority.** State and Provider each represent and warrant to the other that the person signing below has all requisite legal power and authority to execute this Agreement on behalf of each party and each party shall thereby be bound.

5.13 **Best Price Contingency.** The effectiveness of this Agreement shall be contingent on Provider's Best Price and AMP not being affected by State Supplemental Rebates.

5.14 **CMS Approval Contingency.** The effectiveness of this Agreement shall be contingent on receipt of CMS approval by State.

5.15 **Null and Void.** This Agreement shall be null and void without the written approval of CMS of the terms of this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed by the parties set forth below:

State of Idaho
Department of Health and Welfare
Division of Medicaid

By: _____ **Date**_____
David A. Rogers
Administrator

Merck & Co., Inc.

By: _____ **Date**_____
Richard P. Patrylak
Vice President, Managed Care

1/1/04

ATTACHMENT A

Covered Products

The products to which this Supplemental Rebate Agreement shall apply are the following:

NDC	Brand	Strength
00006-0266	MAXALT	5 mg Tablet
00006-0267	MAXALT	10 mg Tablet
00006-3800	MAXALT-MLT	5 mg Oral Disint. Tablet
00006-3801	MAXALT-MLT	10 mg Oral Disint. Tablet
00006-0074	VIOXX	12.5 mg Tablet
00006-0110	VIOXX	25 mg Tablet
00006-0114	VIOXX	50 mg Tablet
00006-3784	VIOXX	12.5 mg per 5 mL Oral Susp.
00006-3785	VIOXX	25 mg per 5 mL Oral Susp.

1/1/04

ATTACHMENT B

Rebate Formula

Prior Authorization Process Requirements for MAXALT:

- MAXALT is exempt from prior authorization required for Competitive Products.
- MAXALT is not disadvantaged in any way to Competitive Products.

Covered Product (drug name)	Dosage /Package	Unit Type	NDC-9 OR NDC-11	Net Cost
MAXALT	5 mg	Tablet	00006-0266	$
MAXALT	10 mg	Tablet	00006-0267	$
MAXALT-MLT	5 mg	Oral Disint. Tablet	00006-3800	$
MAXALT-MLT	10 mg	Oral Disint. Tablet	00006-3801	$

Prior Authorization Process Requirements for VIOXX:

- VIOXX is the only preferred COX-2 Specific Inhibitor (Coxib).
- VIOXX is not disadvantaged in any way to any other Coxib
- All Coxibs may be subject to prior authorization.

Covered Product (drug name)	Dosage /Package	Unit Type	NDC-9 OR NDC-11	Net Cost
VIOXX	12.5 mg	Tablet	00006-0074	$
VIOXX	25 mg	Tablet	00006-0110	$
VIOXX	50 mg	Tablet	00006-0114	$
VIOXX	12.5 mg per 5 mL	Oral Suspension	00006-3784	$
VIOXX	25 mg per 5 mL	Oral Suspension	00006-3785	$

Supplemental Rebate shall be calculated on a calendar quarter basis according to the following formula:

Supplemental Rebate = ([1]Ingredient Reimbursement) – ([2]CMS Rebate) - (Net Cost)

First Calendar Quarter 2004 Net Costs for MAXALT and VIOXX:
Net Cost for MAXALT – See first Table above
Net Cost for VIOXX – See second Table above

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[1] Ingredient Reimbursement based on the Average Wholesale Price (AWP) as published by First DataBank on the first day of a calendar quarter for the quarter in which the rebate applies;

[2] CMS Rebate as calculated and provided to State by CMS on a calendar quarter for the quarter in which the rebate applies.

1/1/04

12. b. Dentures

i. Dentures provided by a participating Dentist on the basis of the lower of: actual charges; or the Department's Medical Assistance Unit statewide fee schedule.

ii. Payment for dentures provided by an Idaho Licensed Denturest will be based on maximum payment level established by the Department's Medical Assistance Unit or the amount billed, whichever is less. These providers will use the same procedure codes as Dentists.

c. Prosthetic Devices

i. Prosthetic and Orthotic - Services are reimbursed using the lower of the provider's actual charge for the service; or the maximum allowable charge for that device as established by the Department's Medical Assistance Unit pricing file.

ii. Hearing Aids - Payment is made to hearing aid vendors at usual and customary rates; or the maximum allowable charge as established by the Department's Medical Assistance Unit pricing file.

d. Eye Glasses - Payments to providers for eye glasses are made at the lower of: the usual and customary charges; or the Department's Medical Assistance Unit established fee schedule.

13. d. Rehabilitation Services - The rate of reimbursement for each component of ambulatory services included in the State's Medicaid Plan will be established by the Department's Medical Assistance Unit. This reimbursement rate will not exceed the usual and customary charges for comparable services under comparable circumstances in public and private agencies in the State of Idaho.

14. Services for individuals age 65 or older in institutions for mental diseases;

b.& c. Skilled Nursing Facility Services - Refer to Attachment 4.19D.

15. a. & b. Intermediate Care Facilities for the Mentally Retarded - Refer to Attachment 4.19D.

92-3

approved 4/28/92
effective 3/1/92

17. Nurse Practitioner/Nurse Midwives
Obstetrical Services

Nurse Practitioners/Nurse Midwives - The rate of payment for these providers will be at the maximum payment level established by the Department or the amount billed, whichever is less. These providers will use the identical procedure codes as the physicians and will have individual provider numbers.

Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT
59000	NA	59852	NA	99401	$8.67
59012	NA	59855	NA	99402	$17.32
59015	NA	59856	NA	99403	$25.99
59020	$44.07	59857	NA	99404	$34.64
59025	$31.65	59870	NA	99411	NA
59030	$40.12	59899	NA	99412	NA
59050	NA	99201	$23.49	99420	NA
59051	NA	99202	$32.46	99429	BY REPORT
59100	NA	99203	$42.01	99432	$64.11
59120	NA	99204	$56.54	90700	$23.00
59121	NA	99205	$65.97	90701	$17.23
59130	NA	99211	$18.85	90702	$6.33
59135	NA	99212	$24.20	90703	$4.00
59136	NA	99213	$28.27	90704	$18.25
59140	NA	99214	$37.70	90705	$17.55
59150	NA	99215	$56.54	90706	$17.55
59151	NA	99241	$33.24	90707	$35.00
59160	NA	99242	$43.66	90708	$22.30
59200	NA	99243	$52.06	90709	$23.32
59300	NA	99244	NA	90710	NA
59320	NA	99245	NA	90711	$33.00
59325	NA	99271	NA	90712	$16.22
59350	NA	99272	NA	90713	$18.00
59400	$1,039.78	99273	NA	90714	$3.00
5940P	$938.31	99274	NA	90716	$46.00
59409	$567.11	99275	NA	90717	$38.00
59410	$659.72	99341	$33.03	90719	$5.00
59412	NA	99342	$40.29	90720	$38.00
59414	NA	99343	NA	90721	$45.00
59425	$230.90	99351	$22.61	90724	$8.00
59426	$318.13	99352	$33.24	90725	$5.00
59430	$112.52	99353	$44.33	90726	$185.00
59510	NA	99354	$53.73	90727	$4.00
59514	NA	99355	$26.87	90728	$5.00
59515	NA	99358	NA	90730	$63.00
59525	NA	99359	NA	90732	$15.00
59812	NA	99381	$45.94	90733	$11.00
59820	NA	99382	$45.94	90737	$18.68
59821	NA	99383	$45.94	90741	BY REPORT
59830	NA	99384	$56.60	90742	BY REPORT
59840	NA	99391	$31.78	90744	$26.00
59841	NA	99392	$31.78	90745	$42.00
59850	NA	99393	$34.69	90749	BY REPORT
59851	NA	99394	$46.35	Q0158	$35.85

BREAK IN PAGE NUMBER

TN # 94.005 Approval Date: 8-13-94
Supersedes
TN # 93-006 Effective Date: 7-1-94

18. Hospice Services With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. The four (4) rates are prospective rates, there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is as follows:

A. Routine home care - The hospice will be paid the routine home care rate for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

B. Continuous home care - Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day.

C. Inpatient respite care - The hospice will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate.

D. General inpatient care - Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general in patient care except as described in the section of this plan which discusses payment of physician services.

92-3 4/28/92
3/1/92

18. Hospice Care (continued)

E. Other General Reimbursement Items

i. Date of Discharge - For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

ii. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

F. Obligation of Continuing Care - After the recipient's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that recipient's care until the patient expires or until the recipient revokes the election of hospice care.

G. Limitation on Payments for Inpatient Care - Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice or its contracted agent(s).

i. For purposes of computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows:

(a) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).

(b) If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed, then no adjustment is made.

92-3 4/28/92
3/1/92

18. Hospice Care (continued)

(c) If the total number of days of inpatient care exceeds the maximum number of inpatient days computed, then the payment limitation will be determined by:

(1) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.

(2) Multiplying excess inpatient care days by the routine home care rate.

(3) Adding the amounts calculated in paragraphs (1) and (2).

(4) Comparing the amount in paragraph (3) with interim payments made to the hospice for inpatient care during the "cap period".

(d) The amount by which interim payments for inpatient care exceeds the amount calculated in section (c) (4) is due from the hospice.

H. Payment for Physician Services - The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

92-3 4/28/92
3/1/92

i. Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician's services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and x-ray services are included in the hospice daily rate.

ii. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions.

(a) A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay.

(b) Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

H. Cap on Overall Reimbursement - Aggregate payments to each hospice will be limited during a hospice cap period. The total payments made for services furnished to Medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.

92-3

4/28/92
3/1/92

18. Hospice Care (continued)

i. The overall cap will be compared to reimbursement the inpatient limitation is computed and subtracted total reimbursement due the hospice.

ii. "Total payment made for services furnished to Med recipients during this period" means all payment: services rendered during the cap year, regardless of payment is actually made.

iii. The "cap amount" is calculated by multiplying the n of recipients electing certified hospice care durin period by six thousand five hundred dollars ($6, This amount will be adjusted for each subsequent cap beginning November 1, 1989, to reflect the perce increase or decrease in the medical care expend category of the Consumer Price Index (CPI) for all consumers as published by the Bureau of Labor Statis

iv. The computation and application of the "cap amoun made by the Department's Medical Assistance Unit the end of the cap period.

v. The hospice will report the number of Medicaid recip electing hospice care during the period to Department's Medical Assistance Unit. This must be within thirty (30) days after the end of the cap p as follows:

vi. If a hospice certifies in mid-month, a weighted av cap amount based on the number of days following w each cap period would be used.

I. Adjustment of the Overall Cap - Cap amounts in each hosp cap period will be adjusted to reflect changes in the periods and designated hospices during a recipient's ele period. The proportion of each hospice's days of servi the total numbered hospice days rendered to a recipient d their election period will be multiplied by the cap amou determine each hospice's adjusted cap amount.

i. After each cap period has ended, the Department's Me Assistance Unit will calculate the overall cap wit reasonable time for each hospice participating i Idaho Medicaid Program.

ii. Each hospice's cap amount will be computed as foll

(a) The share of the "cap amount" that each hospi allowed will be based on the proportion of total co days provided by each hospice in the "cap period".

92-3

4/28/92
3/1/92

(b) The proportion determined in Section (I) (2) (a) for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the recipient first elected hospice.

(c) The recipient must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicaid recipient during the current cap year.

J. Additional Amount for SNF and ICF Residents - An additional per diem amount will be paid for "room and board" of hospice residents in a certified SNF or a certified ICF receiving routine or continuous care services. In this context, the term "room and board" includes, but is not limited to, all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps. The amount for room and board rate will be based per subsection 1902(a) (13) of the Social Security Act.

4/28/92
3/1/92

19. Case Management Services

A. For the Mentally Ill - Reimbursement will be made at an hourly rate established by the Department's Medical Assistance Unit.

B. For Personal Care Service Recipients - The care plan and assessment will be reimbursed at a set rate established by the Department's Medical Assistance Unit, and will be made at an hourly rate established by the Department's Medical Assistance Unit.

20. Special Services Related to Pregnancy - Payment for Risk Reduction Follow-up, Individual and Family Social Services, Nutrition Services, Nursing Services, Maternity Nursing Visits and Qualified Provider Risk Assessment and Plan of Care will be reimbursed at the lowest of:

A. The provider's actual charge for the service; or

B. The provider's median charge for a given service; or

C. The maximum allowable charge for the service as established by the Department's Medical Assistance Unit on its pricing file.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During Presumptive Eligibility Period - Payment for Risk Reduction Follow-up, Individual and Family Social Services, Nutrition Services, Nursing Services, Maternity Nursing Visits and Qualified Provider Risk Assessment and Plan of Care will be reimbursed at the lowest of:

A. The provider's actual charge for service; or

B. The provider's median charge for a given service; or

C. The maximum allowable charge for the service as established by the Department's Medical Assistance Unit on its pricing file.

TN # 92-3
4/28/92
3/11/92

23. Certified Pediatric or Family Nurse Practitioners - The rate of payment for these providers will be at the maximum payment level established by the Department's Medical Assistance Unit or the amount billed, whichever is less. For maximum payment by procedure code refer to attachment 4.19-B 17 Nurse Midwives Obstetrical Services. These providers will use the identical procedure codes as physicians.

92-3

4/28/92
3/1/92

24. a. Transportation - Payment rates for ambulance services will not exceed the upper limits of Medicare reimbursement. Public transit and charter services, including air ambulance services, are limited to reasonable and customary rates generally acceptable in the community. Payments to individuals using private vehicles are limited to the rates established by the state.

d. Nursing Facility Services for Individuals Under 21 Years of Age - Refer to attachment 4.19-D.

e. Emergency Hospital Services - Refer to Attachment 4.19A and 4.19B-2

f. Personal Care Services (PCS) - Personal Care attendants will be paid an hourly rate established by the Department's Medical Assistance Unit based on nursing home wages as required by Idaho Code. Separate rates will be established for independent providers and PCS agencies. RN and QMRP supervisors will be paid a flat rate per visit which will be established by the Department's Medical Assistance Unit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	MR	Deductibles	MR	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	MR*	Deductibles	MR*	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible QMB Plus	Part A	MR*	Deductibles	MR*	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance

***For skilled nursing facilities, Medicaid will disregard the deductible and coinsurance amounts and pay no more than the difference between the Medicaid allowed amount minus the Medicare Part A payment.**

Minimum payment to non-institutional providers of services for individuals eligible for Medicare and Medicaid will be as follows: Medicaid will pay the lesser of the Medicaid allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	MR	Deductibles	MR	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	MR*	Deductibles	MR*	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible QMB Plus	Part A	MR*	Deductibles	MR*	Coinsurance
	Part B	SR	Deductibles	SP	Coinsurance

***For skilled nursing facilities, Medicaid will disregard the deductible and coinsurance amounts and pay no more than the difference between the Medicaid allowed amount minus the Medicare Part A payment.**